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ABSTRACT

This document presents modified and updated papers from a symposium held to examine alcohol and drug abuse prevention efforts worldwide. It contains 32 papers from 11 countries; papers include: (1) "Community Action on Alcohol Problems: The Demonstration Project as an Unstable Mixture" (Robin Room); (2) "Perspectives on the Community in Action Research" (Harold Holder and Norman Giesbrecht); (3) "Democracy and Community Action Programs" (Stig Larsson); (4) "Problems of Action Research: Some Practical Experiences" (Marja Holmila); (5) "Addressing the Problems of Action Research in the Community: Lessons from Alcohol and Drug Education" (Michael S, Goodstadt); (6) "Paths Ahead for Server Intervention in Canada" (Eric Single); (7) "Environmental Design to Prevent Problems of Alcohol Availability: Concepts and Prospects" (Friedner D. Wittman); (8) "Conducting Community Action Research" (Ann Pederson, Susan Roxburgh, and Laura Wood); and (9) "Lessons from Community Action Research Experiences and Suggestions for Future Prevention Projects" (Norman Giesbrecht, Peter Conley, Robert Denniston, Louis Gliksman, Harold Holder, Ann Pederson, Robin Room, and Martin Shain). The other 23 papers consist of brief and extended case studies on particular action research projects that were recently completed or, in some cases, are underway. Reports of four workshops, the symposium program, and a list of contacts are appended. (NB)

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OSAP Prevention
Monograph-4

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RESEARCH, ACTION, AND THE COMMUNITY: EXPERIENCES IN THE PREVENTION OF ALCOHOL AND OTHER DRUG PROBLEMS

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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The contents of this volume are based on
presentations and deliberations
at the Symposium on Experiences with
Community Action Projects for the
Prevention of Alcohol and Other Drug Problems,
held at the Guild Inn, Scarborough, Ontario, Canada
March 11 through 16, 1989

This was a thematic meeting of the
Kettil Bruun Society for Social and Epidemiological Research on Alcohol

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OSAP Prevention Monograph–4

RESEARCH, ACTION, AND THE COMMUNITY: EXPERIENCES IN THE PREVENTION OF ALCOHOL AND OTHER DRUG PROBLEMS

Sponsors:
Office for Substance Abuse Prevention
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Health and Welfare Canada

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Norman Giesbrecht
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This monograph is the final report of the Symposium on Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems, held in Scarborough, Ontario, Canada, March 11–16, 1989.

The views expressed in the presentations herein are those of the listed authors and may not necessarily reflect the opinions, official policy, or position of the Addiction Research Foundation; Health and Welfare Canada; the U.S. Office for Substance Abuse Prevention; Alcohol, Drug Abuse, and Mental Health Administration; Public Health Service; or Department of Health and Human Services.

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Foreword

This volume, the fourth in a series of prevention monographs, represents an international collaborative effort between the Office for Substance Abuse Prevention, the Addiction Research Foundation in Toronto, Canada, and Health and Welfare Canada. The monograph is based on the presentations, deliberations, and findings of the "Symposium on Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems," conducted in Toronto during Spring 1989.

This volume describes prevention programs in a knowledge-based manner and incorporates state-of-the-art findings and practices drawn from recent scientific research and expertise from the field. Because the most successful prevention programs are likely to be those initiated and conducted by communities themselves, this volume contains conceptual papers, case studies, and workshop reports, which all focus on community action projects.

Containing 32 separate papers authored by representatives from 11 countries, this volume describes the various problems encountered while developing and initiating action research programs in various settings (for example, schools, workplaces, and drinking establishments). This volume can be considered a tangible exhibit of a multinational commitment to prevention and to the future it offers. It illustrates our initiative toward providing comprehensive preventive program advice for community workers, health care providers, and social service and other professionals concerned with addressing alcohol- and drug-related problems.

We hope that the knowledge shared in this volume will stimulate and direct worldwide alcohol and other drug prevention programs and suggest pathways for similar international partnerships for the future.

Elaine M. Johnson, Ph.D., Director
Office for Substance Abuse Prevention

Preface

This monograph grew out of a symposium on "Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems," which was held in March 1989 in Scarborough, Ontario. The papers have been substantially modified since the symposium, and new material developed based on the participants' comments and general discussion during the plenary sessions. The book is not, therefore, simply a proceedings document; it also represents the postmeeting reflections of the authors and editors.

The experiences reported in these pages reflect enthusiasm for field research and an interest in effectively combining potent prevention strategies with sound evaluation. The papers also reflect the frustrations encountered when research-oriented professionals are confronted by disinterest and widely shared cautions about the utility of prevention initiatives. At times, the papers refer to problems arising from hasty sponsorship of unproven projects or those without an evaluative component, ongoing sponsorship of projects with an uninspiring track record, or inadequate sponsorship of novel projects with unique potential.

If unusual candor is therefore evident in these papers, it is because the organizers of the symposium explicitly encouraged participants to take a reflective, confessional stance. Our call for abstracts emphasized the following:

> The symposium aims to document and assess experiences with research-oriented community action and community development projects on alcohol and/or other drug issues. A number of such projects with full before-after evaluations have been undertaken in recent years, and the symposium aims to record and draw conclusions from the processes and events of these projects....
>
> The main emphasis of the paper for the meeting should be on process. Of particular interest are the interactions between the change agents and/or researchers and the community, modifications of the study's aims and means during the course of the study, and any lessons that the study's experience suggests for future work. It is expected that the papers will also indicate problems encountered in the course of community intervention experiences and attempts at their resolution....

Initially, the symposium planners viewed community action research as an activity initiated by researchers with scholarship as a central objective. In time, partly because of the nature of the abstracts received, an appreciation of the diversity of action research evolved. It was evident that there were many projects aimed at preventing alcohol and other drug problems in which research was but one component of the overall program, rather than the program's raison d'être. The projects reported here represent this broader perspective.

Throughout the symposium and in these papers, researchers and programmers reported on somewhat unusual arrangements—namely, working together in dynamic community-oriented projects. Presenters and participants took the additional risk of reflecting on problems encountered, acknowledging the shortcomings of their prevention initiatives, or raising questions about sponsors' or supporters' commitment to the projects.

The intent of this collection is twofold: to give a fuller and more balanced analysis and interpretation of these unique community experiences than is feasible in other publication avenues that tend to be oriented to outcomes rather than illumination of process experiences; and to provide others with similar interests and enthusiasms with some suggestions and advice so that their own experiences might be more rewarding and productive.

It is hoped, therefore, that the risk-taking has paid off in that reflection and documentation in the course of research-oriented enterprises are their own reward and that such reflection will prove useful to those who continue to take bold steps in community-oriented prevention initiatives.

The structure of the book is as follows: Robin Room's opening paper provides an overview of recent community action on alcohol problems, including an interpretation of three major initiatives from the 1970s. This introduction is followed by three papers that raise conceptual issues: (1) aspects of the community that are downplayed or overlooked in prevention research (Holder and Giesbrecht); (2) issues related to democracy and prevention interventions (Larsson); and (3) problems of encouraging and accommodating lay initiatives in the course of action research (Holmila).

These themes and others are elaborated in the body of the book, which consists of two sections of case studies. Here authors report on particular action research projects that were recently completed or, in some cases, are under way. Although it is not feasible to identify the themes of 23 papers in a few pages, we offer some observations here.

These papers reflect divergent views on the nature of the community and on what constitutes community-based action research. Similarly, differing perspectives are evident with regard to which duties, divisions of labor, or relationships are advisable among researchers, programmers, and community personnel. In a few instances, genuinely collaborative endeavors were feasible; in others, at least one of the three parties is somewhat peripheral to the overall enterprise.

The papers explore a wide range of problems, from questions of designing, planning, building local support, implementing, sponsoring, and evaluating projects in order to foster mutual understanding and appreciation between researchers and more action-oriented personnel. Problems are identified, and on a case-by-case basis information is provided on how they were managed. In general, although guidelines can be offered on how to anticipate problems and plan for more effective responses, research-oriented prevention initiatives in the context of shifting local agendas will present unique challenges in each setting.

Furthermore, without a taxonomy of communities or a substantial tradition of research pointing to combinations of interventions that hold the greatest promise, we must continue to rely on a blending of educated selection of options, planned opportunism, and ongoing reflections on our trials and errors.

Apparently a good project can be undermined in countless ways. These case studies allude to active resistance as well as to barriers that are unwittingly placed in the way of prevention projects. It can be deduced from several papers that reflecting on these experiences and reporting them may be less painful with the distance achieved after time has passed or venues have changed.

The concluding sections look to the future. The papers by Goodstadt, Single, and Wittman indicate how recent experiences point to future possibilities with regard to community-oriented initiatives involving educational institutions, licensed premises, or community structures and institutions in general. In the essay by Pederson and others, the key themes and commentaries from the discussions and deliberations of the plenary sessions of the symposium are drawn together.

In the summary, the editors outline the key lessons of the monograph and in turn provide points to consider in future endeavors. It is hoped, therefore, that this monograph not only provides a forum for explicit statements on the experiences of doing action research, but that it is also a source of constructive guidance for new initiatives in this area.

This monograph was made possible by the contributions of the symposium sponsors. The Addiction Research Foundation, Health and Welfare Canada, and the U.S. Office for Substance Abuse Prevention contributed special funds and staff time and facilitated practical arrangements. These contributions made it possible to hold the meeting and produce this book.

Although it was possible to produce the monograph in about a year after the symposium, the plans for the meeting itself go back several years. A suggestion by Robin Room led to a discussion, a short purpose statement, and eventually to planning meetings in Berkeley and Toronto. The preliminary discussions in 1984 were held in the Lord Nelson Hotel in Stockholm just before a conference organized by Kettil Bruun, whose work on policy and action-oriented research on a number of alcohol and drug issues is widely known. It is fitting therefore, that the symposium that later emerged was designated as a thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol.

It is hoped that the contents of this volume encourage further initiatives that combine action and research to reduce alcohol and drug-related problems in many settings and countries.

Norman Giesbrecht
Research Scientist, Alcohol Policy Research
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Acknowledgments

Without the support of the three sponsoring agencies it would not have been possible to hold the symposium on community action projects or prepare this monograph which evolved from it.

Under its "Action on Drug Abuse" program, Health and Welfare Canada provided financial support through a research grant from the National Health Research and Development Program and funding from the Health Promotion Directorate: we wish to acknowledge the staff of the Directorate for their assistance in finding resources and planning the symposium, for their assistance in setting up the grants, for contributions to the manuscript review meeting, and for reviewing draft text for the monograph.

Similarly, funding from the U.S. Office for Substance Abuse Prevention is gratefully acknowledged. Furthermore, staff of the Division of Communication Programs participated in several aspects of the preparations leading to this document, particularly with regard to the logistics of manuscript editing and production.

The Addiction Research Foundation was the host of the symposium and the locale where a large share of the manuscript preparation and editing took place. Many individuals contributed by supporting the plan for the symposium, managing symposium-related logistics, editing draft sections of this monograph, acting as rapporteurs, transcribing text for the monograph, and arranging project accounts.

We are pleased that it was possible to arrange the symposium as a thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol and grateful for the interest of society members in this meeting.

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CHAPTER 1

Introduction

Community Action and Alcohol Problems: The Demonstration Project as an Unstable Mixture

Robin Room

Matters of Definition and Focus

This paper focuses on evaluated community action programs to reduce the rate of alcohol problems. The idea for a symposium on this topic arose in discussions between Norman Giesbrecht and myself while at a meeting hosted by Kettil Bruun in Stockholm in November 1984. In the preceding few years, we had noticed a number of such projects had been started in several countries. In the general nature of such studies, what made its way into the scholarly literature—thus becoming a cumulating tradition of knowledge—was the formal outcome evaluation of each study. From informal discussions with researchers involved in such studies, we knew that a rich store of experiences existed from the processes of these project reports. However, the knowledge of these processes tended not to cumulate—particularly as a researcher who had gone through the intense experience of such a project was often in no hurry to sign on for another! The idea for the symposium, then, was to bring such experiences into a common frame and to create a basis for accumulating such knowledge.

As the discussions continued among a wider circle in preparing for the meeting, it became apparent that the boundaries around its focus were often fuzzy. By and large the focus is on prevention rather than treatment programs, but treatment-based programs that reach outside the clinic door and endeavor to treat the community are at least marginally in our spotlight. Primarily the focus is on programs targeted at the general community, rather than on special populations reached through particular institutional systems. In particular, given the emphasis in North America on school-based prevention programs, community-based has sometimes been used to mean any non-school-based program (which was essentially the distinction between the Youth and Community branches in the old National Institute on Alcohol Abuse and Alcoholism

(NIAAA) Division of Prevention). It seemed wise to take a relatively inclusive stance on this, including within the frame of community action programs, for instance, programs operating on a college campus or through labor unions.

The focus on community was both central to the conference and problematic. Volumes have been written about the definition of community (e.g., Gusfield 1975). In the present context, the meaning is primarily geographic but also included are elements of the alternative meanings suggested by *communitas*. Usually what is meant by community is a relatively local geographic area, sometimes a local political division (a town, a municipality, a county) and sometimes a subdivision (a neighborhood, a workplace, a college campus). A common methodological difficulty in designing community-based projects has been arriving at an appropriate geographic or other boundary for the project's purposes.

A community, in the present context, is usually compact enough that in principle one person in it can get together with another. Many of the community actions we are considering involve face-to-face communication and activity—but not all of them, since communication through media is also often involved. Primarily our focus is on actions organized within the community and dealing with problems in the community. These boundaries hold implications for the kinds of measures, actions, and problems involved.

The problems of alcohol most apparent at a community level differ in some ways from those apparent at a national level. Alcohol-related traffic casualties, crime, and family violence will often be high on the agenda of community health and social agencies. Minor public disorders—loud, late-night roistering, beer cans on lawns, urine in doorways—frequently loom large in complaints about drinking-related problems at the local neighborhood level. Parents' fears about their teenage children's drinking find frequent expression.

By and large, local communities are more concerned with the immediate consequences of drinking events than with the cumulative health or social-role toll of long-term heavy drinking. Cirrhosis or neck cancer mortality is too rare and loss of productivity is at too aggregate a level to be highly visible within the community. (One of the attractions of the alcohol trade as a source of national revenue, in fact, is that many of the expenses are borne locally while the revenue comes in nationally, and that, while local expenses are often immediate, the expenses borne nationally are often delayed.)

Community-level actions also tend to have particular aims and forms. Taxes on alcohol are usually set at other levels, as is the general criminal code. Local governments may have some power to criminalize and to pass local alcohol control measures, but these powers are conditional on and constrained by State, provincial, or national legislation. Community-level organizing may, of course, be directed at changes on other levels. For instance, in the United States a local chapter of Mothers Against Drunk Driving may lobby the State legislature for a change in the drinking-driving laws. But our primary focus here is on actions aimed within the community. These actions typically take such forms as community organization and mobilization, networking and alliance making, educational and persuasive programs, local legislative actions, and agency or institution building.

Community action in the present context is thus broadly defined and includes activities autonomously undertaken by members of the community. It also includes activities stimulated among community members by community organizers, health educators, or other professional or nonprofessional change agents, who may be acting on their own or for an organization. And community action has also often included work by professional or semiprofessional health, social, or educational workers—for instance, a professionally run program to train heavy drinkers in the community to monitor their drinking. But such professional actions are usually only regarded as community actions when the professional goes to the client rather than vice versa—when they are undertaken in the community rather than in a clinic or private office. Many of the projects we consider involve one or more change agents in the community employed by or acting on behalf of an organization that is directed from outside the community.

Finally, the focus is on evaluated projects, but again with a broad definition of the term. In some cases assessment might be a better term. The important consideration, as we discussed the terms for the symposium, was that researchers had been drawn away from their desks and had wet their hands in the whirlpool of community action, even if only as an observing evaluator. We thought that there was much to be learned from what those people with research training and sensibilities could report on their involvement in community action programs.

The Prehistory of Evaluated Community Action Projects in the Alcohol Field

Our field of focus requires the conjunction of three elements in the same activity or project: an orientation to the prevention of alcohol problems as an important field of action; a belief in community action as a strategy of change; and a commitment to formal evaluative techniques. Only within the past 15 years have these three elements come together. Each of the elements, however, has had a substantial and separate previous existence.

Community-level actions to reduce alcohol problems have a lengthy history. Faced with the ravages of the gin epidemic in 18th-century London, Henry Fielding and other London magistrates worked tirelessly and eventually somewhat effectively for increased alcohol controls (Coffey 1966). The British system of alcohol control through licensing magistrates gave flexible powers to local authorities to deal with problems of alcohol in the community.

Community-level action on alcohol problems really came into its own with the advent of the temperance movement after the 1830s. As constituents of a many-sided mass movement, temperance organizations operated in terms of a wide network of local groups. Temperance lectures and organizers moved from one community to another galvanizing support and action. From the first, temperance activity was focused at the community level, and the movement maintained an active attention to the community level even as it also turned to state and national levels in the second half of the 19th century (see, for instance, Blocker 1985). From a temperance perspective, organizing and acting at the local level had several advantages. It spoke to the level at which alcohol problems were most keenly and personally experienced. It built commitment and provided communal activities for its members. It fitted into a strategy of "salami tactics," of drying the country up one town or county at a time. And it complicated and raised the costs of doing business for the alcohol trade by imposing different conditions and requirements in different communities.

As the temperance movement turned prohibitionist, one response to it took the form of a small, elite-based alcohol control movement (Levine 1983). The first focus of alcohol control advocates was on government ownership of the alcohol trade, initially at the municipal level. Besides its wide adoption in Scandinavia, the "Gothenburg system" of municipal hotels or dispensaries was instituted on a scattered basis in many English-speaking countries, including the United States and Australia in the 1890s, Britain during the First World War, and New Zealand in the 1940s and later (Room 1987; Stewart and Casswell 1987). Municipal ownership had the advantage of bringing together at the same government level both the economic benefits and the social and health costs of drinking. The disadvantage was that the alcohol trade was sufficiently profitable that revenue considerations often dominated local decisionmaking. In the long run, government ownership schemes gravitated to the state or national level.

An alternative alcohol control formulation focused on a much more rigorous and detailed state control while the trade remained in private hands. This formulation was adopted for most of Britain during the First World War through the Central Liquor Control Board (Smart 1974). Again, the drift over time was toward an enlarged state or national role in alcohol control, although local government frequently had an active role to play. From our present perspective, both in its municipal ownership and in its license control formulation, the alcohol control movement was more focused on government regulation than on community action. But it did forerun our present concerns with a strong emphasis on what could be defined as evaluation studies of prevention measures.

A book like Catlin's (1931) gives strong evidence of a cumulated tradition of experimentation and experience. In particular, during the First World War the British board operated with a flexible experimental orientation, akin to modern action research (see Holmila in this volume) in its willingness to adjust its measures in the light of experience. One can even find examples of formal experimental studies, e.g., of the effects of different opening hours for taverns at the factory gates on the incidence of factory injuries (Collis 1922). But in the changed cultural climate of the 1930s in English-speaking countries, the alcohol control tradition of community-level experiments in alcohol policy was soon forgotten.

In Scandinavia in the same period, the innovation of community-level temperance boards provided another dimension to community action on alcohol problems (Christie 1965; Rosenqvist and Takala 1987). While the main focus of these lay boards was on warning and if necessary compelling treatment of problematic drinkers, the boards also were generally responsible for community action on alcohol problems. It might be noted that the primary reason for the disappearance of the temperance board systems in recent years has been a growing unease over their inherent infringement on privacy rights and over compulsory treatment in general. Effective community action projects focusing on valued everyday behaviors like drinking are likely eventually to bump into issues of privacy and limits on coercion.

As individual-level community surveillance efforts came under attack in postwar Scandinavia, a tradition of community experimental studies with a rigorous evaluation design came to the fore particularly in Finland. Because the Finnish alcohol research effort was attached to the state alcohol monopoly, the research tested mainly the effect of changes in the monopoly's sales practices (e.g., Kuusi's famous study of the effect of opening a liquor store in country towns); relatively little attention was paid to collective actions within the community (Bruun 1961; Kuusi 1957). Today the well-developed Scandinavian tradition of prevention evaluation studies in the alcohol field still is concerned more with the effects of changes in regulations and availability than with the effects of community organization and action.

The idea of community action on alcohol problems resurfaced in the United States in the late 1940s but with a quite different orientation. When Selden Bacon wrote about "The Mobilization of Community Resources for the Attack on Alcoholism" (Bacon 1947), the paper became an organizing manual for the nascent alcoholism movement on building alliances to secure treatment for alcoholism as a disease. For the next two decades in the United States, discussions of community action on alcohol issues were primarily concerned with building a treatment system for alcoholics.

In the United States and other societies, self-conscious ideologies of community organization, action, and development came to the fore in the 1960s. The emphasis on empowerment of community residents and neighborhood organizations was conveyed by slogans ranging from the War on Poverty's "maximal feasible participation" to the Black Panthers' "power to the people." However, this shift had little immediate effect on activities concerning alcohol problems. Until well into the 1970s, the dominant model of action on alcohol issues in North America was the provision of professional or paraprofessional treatment services for alcoholism. This framework constrained perspectives on prevention to such activities as case finding and promoting the disease concept of alcoholism.

By the mid-1970s, a new alcohol problems perspective, first propounded in restricted circles in the 1960s, had begun to make headway in national, state, and provincial agencies. An early center of the new thinking was the Addiction Research Foundation (ARF), which had begun to point out the relevance of the overall level of consumption to the levels of alcohol problems in a society (Room 1978). By the mid-1970s, NIAAA had a Prevention Division and by 1977 it had begun to shift its thinking toward a broader definition of prevention strategies for alcohol problems. Both ARF and NIAAA operated under a primary mandate as research organizations, and the form that their new commitment to prevention programming took was evaluated demonstration projects, initially primarily for youth and in the schools, but as time went on increasingly in the community. A model of the evaluated community action program to prevent alcohol-related problems began to take shape.

Evaluated Community Action Projects 1976–1982: Notes and Conclusions of an Interested Observer

In the late 1970s and early 1980s I was involved at least peripherally in three research-oriented programs or projects that involved community action to reduce alcohol problems. In each case I will first give a brief history of each program or project, before attempting to draw some lessons from its experience.

The World Health Organization (WHO) Study of Community Response to Alcohol-Related Problems

This project, undertaken in 1976 in Mexico, Zambia, and Scotland, has been amply documented elsewhere (Ritson 1985; Rootman and Moser 1985). The overall aim was to study and to demonstrate ways to improve the community response to alcohol-related problems. The first phase of the project, running from September 1976 to July 1981, which absorbed most of the project's resources, involved a series of community epidemiological and agency studies.

In a second, more thinly funded phase, running from October 1979 to March 1983, the study team in each country was to attempt to improve the community response to alcohol problems and to assess the results (resources were too thin to allow for a full evaluation). In each study site, community organizing activities were undertaken locally, along with a national policy-setting meeting. The emphasis in the local activities at each site was somewhat different.

In the Edinburgh metropolitan area, with a relatively rich assortment of existing social and health agencies, the study's activities contributed to planning by an ongoing council of community agencies to improve the community response to alcohol problems. In a district of Mexico City unsuccessful efforts were made to recruit local professionals to discuss and act on the project's findings. In the end the discussions were held with women's groups affiliated with a local family center. The outcome was not community-level action but rather the formation of an Al-Anon mutual-help group for wives of heavy drinkers. The Zambian team attempted to establish participatory community action groups in each of three study communities, but found that it was difficult to maintain a focus on alcohol issues and that local efforts ceased when the project team left. At the international level a major product of the second phase was the *Guidelines for Investigating Alcohol Problems and Developing Appropriate Responses* (Rootman and Moser 1984).

The initial idea of the project arose around the edges of a 1975 WHO Meeting of Investigators that marked the cumulation of work on an earlier NIAAA contract to develop "criteria for identifying and classifying disabilities related to alcohol consumption" (Edwards et al. 1977). NIAAA wished to support the further development of an alcohol program at WHO to lend validation to alcoholism as a public health concern, and a new project was needed as a vehicle for extrabudgetary support. Initially, the project was to be a followup of the earlier project, developing and field-testing the criteria across different cultures.

However, this aspect faded in significance over time. The central focus of the project came to be on examining the "two worlds of alcohol problems"—in clinical samples and in the general population—and on this basis improving the community's response to alcohol problems. As noted in a discussion of the intellectual background of the project (Rootman and Moser 1985), this issue had come to the fore particularly in the work of research groups in Berkeley and South London, members of which played a large advisory role in the eventual project. The emphasis on action at the community level came particularly from British experience in Edinburgh and London, eventually formalized in the idea of the "community alcohol team" acting as a change agent in the community (see Rootman and Moser 1984). The emphasis on community action, which became stronger as the project proceeded (Clement 1987; Rootman and Moser 1984; Ward 1987), was well suited to the house philosophy of WHO by the late 1970s: WHO was increasingly focusing its overall program on the needs of developing nations, and in that context was emphasizing the development of primary care in the community, as opposed to emphasizing large teaching hospitals in capital cities.

I prepared an initial draft proposal for the study at the 1975 meeting. A later draft prepared by Alan Cartwright, who had been involved in the South London project, was submitted through the NIAAA grant review process. When it became apparent that the project would not be funded as a grant, NIAAA staff switched the project to a contract, with the wording of the contract tasks drafted by NIAAA staff. A final agreement with WHO was reached under the pressure of the closing days of fiscal year 1976. While a variety of studies and activities were called for in the contract, what the study spelled out with the greatest specificity were general population surveys of each study site. These surveys came to occupy a large portion of the resources and energies of the first phase of the project.

The contract specified that there were to be three study sites, one in a developing country, one in a developed country, and one in a country in a "process of rapid social change." Drawing on her wide knowledge of potential collaborating investigators, Joy Moser, the responsible WHO staff person, chose as investigators three psychiatrists—Alan Haworth, Bruce Ritson, and Guillermo Calderon—who had common interests in social psychiatry, in alcohol studies, and in research, as well as the potential to assemble a project team and local resources. On this basis Zambia, Scotland, and Mexico were chosen to fill the three slots specified in the contract. Each collaborating investigator was encouraged to form a team with social scientists and/or with a local social research agency capable of carrying out population surveys. In Mexico and Zambia the second phase of the project was actually carried out by the research agency rather than by the original investigator. The project's start was delayed for some months while an overall project director, David Hawks, was found and relocated in Geneva. At the end of Hawks' 2-year leave from his position in Britain, Irving Rootman from Canada carried the project through to completion as project director.

Some lessons of the study as a community action project. The WHO Community Response Study was ambitious and multifaceted, and an intense experience for all involved. The lessons to be drawn from the study lie in many directions, and participants will no doubt differ on them. Here is simply my version of the lessons relevant to evaluated community action studies.

- "Community" turned out to be a problematic term. The three study site teams, acting under an agreement to choose study areas that included both urban and rural populations, made different choices, reflecting technical considerations for the general population survey, national conditions, and emphases on different aspects of the study.

As it developed the project became concerned with alcohol issues in a variety of social and health agencies—for example, in mental health services, social welfare offices, police stations, and hospital emergency services. Usually each service turned out to have its own catchment areas, so that the relevant community varied widely between, say, a police station, which had a relatively local catchment area, and a mental hospital, which served a much larger area. This methodological difficulty pointed, in fact, to a substantive finding: One of the difficulties in integrating community response to alcohol problems is that, as multisectoral problems, they are responded to by services with widely varying catchment areas.

The issue of the relevant level of aggregation defined as the community also arose with respect to the community action phase of the project. The experience in Zambia, where a very local level of aggregation was used in a community organizing effort, suggested that for a relatively segmental issue like alcohol problems, a relatively large community may be needed to sustain the civic energy for action. Conversely, actions pitched at the level of a whole metropolitan area may lose the grassroots quality necessary for community organization and empowerment.

- The project took a broad, but often not very well-defined, view of the kinds of action that constituted "improving the community response." The North American social welfare literature distinguishes between three models of "community organization practice": a "locality development" model, with members of a local community seeking consensus in task-oriented groups; a "social planning" model, with professional planning on behalf of a consumer-public; and a "social action" model, in which constituents are mobilized around issues, often in pursuit of basic institutional or structural change (Rothman and Tropman 1987). The different models involve different roles for the change agent, acting as a catalyst, coordinator, and skill-teacher in the locality development model; as a fact gatherer, programmer, and negotiator in the social planning model, and as an agitator, advocate, and negotiator in the social action model.

Traditional models of public health action, viewing health as a professional concern, followed what in social welfare terms would be called a social planning model. Along with public health generally, WHO has been turning toward a more participatory model of public health action, usually conceptualized in terms like the locality development model. Particularly as public health interests have come up against vested economic interests, many public health workers have tended to move toward the more confrontational social action model.

The Scottish project, started when a community planning process was already well under way, fitted into a predominantly social planning model, centering around an established planning Committee on Alcohol-Related Problems (CARP) composed of representatives of local agencies. A major element in CARP's recommendations, however, was for the funding of Community Alcohol Teams, which would represent a shift to a locality development model. Both in Mexico and Zambia, there were some leanings toward a social action model. These leanings, which were encouraged by the Geneva WHO staff, were associated with some turbulence in the projects: the original director of the Mexican study resigned in the wake of conflicts of perspective with more activist younger colleagues, and the second phase of the Zambian project was put in the hands of a new director more inclined to a social action model. In the end the Mexican project tried a locality development model, and only in Zambia was social action given a trial.

The Zambian project set out "to be action oriented and community participative." A 1980 planning document by the Phase 2 director stated that "it was expected to be dialectical, with conflicting points of view emerging both among different factions within the study communities and among different members of the research team." However, in the event, the Zambian research team felt that a "structured directive process," with a primary flow of information and influence from the project team to the community, "gradually became explicit as the research progressed"—a process we might see as closer to the locality development model (quotes from Kalumba et al. 1983, pp. 1, 2, 26).

The Zambian team produced an interesting and exemplary documentation and assessment of their work, which unfortunately is not widely distributed (Kalumba et al. 1983). It is therefore worth quoting a few of their comments on the work of the Community Alcohol Groups (CAGs) that were the primary instrument of action.

> CAGs were political creatures. Their survival depended on the nature and quality of support their extremely volatile environment could afford to give them. The roles CAGs were expected to assume put them within the battle ground of community power politics. A definition of mission conforming to the mainstream activities of dominant community institutions was inevitable in the absence of an independent support base (Kalumba et al. 1983, p. 20)

> CAGs as autonomous units could not survive as their concerns were being constantly coopted by other units. Clearly a double-bind situation emerges in that while the research team was attempting to place alcohol-related problems within the broader community concerns, by so doing the

focus of responsibility became dispersed across too many other groups thereby making it impossible for CAGs as such to survive.

> Focus had to be placed on those aspects of alcohol problems which increased the likelihood of being integrated into the mainstream of these other groups' practices. This is regardless of whether such a problem caused the most immediate real "threat" to the community based on available data (Kalumba et al. 1983, p. 18).

Alcohol-related problems provided material not so much for community action, it seems, but for community control (Kalumba et al. 1983, p. 19).

Thus, in one community youthful drinking—not a major problem according to the survey data—became "an easy acceptable noncontroversial problem for local leaders to handle"; in another community, illegal brewers became the target as "an obvious vulnerable group."

- The Zambian Phase 2 report also discussed the discrepancies in perspective between the multiple constituencies involved in the project. WHO's interest in alcohol problems, the interest of the national government, and the interest of the change agents, may not be matched in the community. "The concerns of those outsiders who would wish to help a community do not necessarily coincide with those of the community itself. Where such outsiders wield power, the gentle reception from the communities cannot always be interpreted as acceptance of their mission" (Kalumba et al. 1983, p. 43). "Issues such as whether or not community relevant issues which require immediate attention are sacrificed in order to attain the basic aims of external funding sources must be considered" (Kalumba et al. 1983, p. 33).

International governmental organizations may offer a particularly difficult environment for full reporting of controversial research findings. The direct constituency of WHO, for instance, is national ministries of health, and WHO is necessarily sensitive to making any implied criticism of a particular nation's policies. More broadly, in the context of an international governmental organization, all cross-national comparisons tend to be regarded as potentially invidious.

The California Prevention Demonstration Program

The inception of what became the California Prevention Demonstration Program came in the months after Jerry Brown's initial election as Governor of California in November 1974. The State legislature had passed a bill providing for a small earmarked tax on alcoholic beverages to be used to fund public alcohol treatment agencies. Brown decided to veto the bill but, to avoid seeming in the pocket of the alcoholic beverage industry, wanted at the same time to announce an initiative to reduce alcohol problems.

At the invitation of the State Office of Alcoholism, Don Cahalan and I prepared a plan for a three-community evaluated demonstration project, modeled loosely after the Stanford Health Disease Project. In one community both community action and media approaches would be used; in another a media-alone approach would be used; a third community would serve as a control. The project would be organized under academic direction, just as the Stanford project had been. We heard indirectly that the Governor had rejected our plan as too academic, and instead was proposing a big media campaign in the largest market in the State—the Los Angeles area.

In the end, the State office adopted a compromised version of the three-community design, with separate contracts for the media component, for the community action component, and for the evaluation. Coordination was to be through the State's project officer and by occasional coordinating meetings. Community action was to be carried out by the county Office of Education in the designated county; under the contract, community workers were to be hired and supervised by an office that otherwise primarily acted as a curriculum center for local school districts.

Larry Wallack served as the study director on the evaluation and did an extraordinary job under somewhat constrained circumstances. Although the project started out with a wide variety of evaluative methods, including ethnographic studies and charting of social indicators, in the end budget cuts limited the summative evaluation to a comparison of patterns in three general-population survey samples: one interviewed before any intervention, one after the first wave of intervention, and the third after the third wave of intervention. The effects of the interventions were modest. Respondents in the target communities could usually recognize the campaign's commercials, and a majority interpreted them correctly. They showed some signs of increased awareness and knowledge about alcohol issues. But no evidence exists of changed attitudes or behavior concerning drinking (Wallack and Barrows 1982-83; see also Caetano 1982; Cahalan 1977; Wallack 1978a, 1978b; Wallack 1979; Wallack and Barrows 1981).

Some lessons of the study: The politics of evaluation. My comments are offered as those of a colleague who watched the study process over Larry's shoulder. My focus is on the politics of the evaluation. The study was born as a political decision and continued to be politicized for as long as it was politically visible.

- The first wave of television spots were pulled off the air at the last minute by Governor Brown, after the State wine industry complained that it was unfair and immoral of the State to use sexual suggestion and gambling to sell not drinking too much. Also, an influential State Assemblyman had introduced a resolution denouncing the ads as "sexist, racist, moralistic, and prohibitionist." The Governor explained that "one has to take into account the sensibilities of people who are morally opposed to gambling, who believe that sexually explicit ads are not appropriate for a state agency even if the end is appropriate" (quoted in Wallack 1978b, p. 16). These remarks created an immediate furor that resulted in the ads receiving considerable visibility through news programs. But the decision also resulted in a constriction of messages for the remade spots, as well as in a smaller audience because of the loss of the favorable terms of the initial media buys. Since the basic theme was showing the advantages of not drinking too much, what was left to advertise as advantages in the first wave were sports skills—specifically, that one does better at arm wrestling and dart throwing with fewer drinks. As a result of the Governor's intervention, a new criterion of appropriateness was applied to the program's activities, reflecting "an awareness of political realities—i.e., the State does not wish to offend any of its constituents" (Wallack and Barrows 1981, p. 176).

- While the approach was to stress the virtues of not drinking too much, the Governor felt "that it was inappropriate for the State to be suggesting precisely how much a person should drink" (Wallack and Burrows 1981, pp. 20–21). Accordingly, no material was actually to specify a number of drinks as the limit of "not too much." In the prototype case in the first year of the project, a TV character's statement to a bartender, "No thanks, I've had one," was changed to "No thanks, I've had enough" (Wallack 1978b, p. 19). (Despite the ruling, one radio spot in Spanish actually specified "two drinks" as a limit, apparently without coming to the State office's attention.) Television viewers often confused the campaign's spots, particularly those intended to parody industry spots, with beer company commercials. The difference between the benefits of drinking and the benefits of drinking not too much turned out to be a subtle difference to convey in 30 seconds.

The campaign's initial slogan, "Winners quit while they're ahead," was not recognized to be aimed at drinking by many in the audience. Later in the campaign "drinking" was inserted with a carat, so that the slogan read "Winners quit drinking when they're ahead." The slogan used in Spanish translated to "Winners—they know when to say enough." The winners slogan was chosen by the media contractor with an eye more toward catchiness than message; then the argument for retaining it became that a substantial investment had already been made in establishing recognition of the slogan.

On the other hand, a mock warning label, "Caution: Too Much Drinking Can Be Dangerous to Your Health and Happiness," was used in the first-year spots, reduced in size in the second-year spots, and dropped altogether in the third year (Wallack and Barrows 1981, p. 17). By the late 1970s, the alcohol beverage industries were actively fighting on a national level congressional legislation to impose warning labels on alcoholic beverage containers and found even a mock warning label, made up to resemble the warning label on cigarette packages, unpalatable.

- In the evaluator's view, the blurred messages reflected some confusion about the goals of the study. The State's Requests for Proposals (RFPs) for the study specified short-range goals of changing awareness, knowledge, and attitudes about drinking practices and problems; medium-range goals of changing drinking behavior and lowering per capita consumption; and long-range goals of reducing indicators of alcohol problems. But the RFPs also suggested...

> establishing the idea that abstinence could be an attractive normative behavior. Individuals associated with the program expressed quite a variety of goals, and this suggests that to some degree at least there was a lack of consensus about just what the alcohol prevention demonstration program was all about. An Office of Alcoholism staff person stated that a purpose of the prevention program was to raise the political visibility of alcoholism programs. Several people said that the primary objective of the program was to reduce overall consumption of alcoholic beverages; others saw the reduction of problems which result from alcohol use as the goal (Wallack and Barrows 1981, p. 12).

- Targeting and programming decisions gave priority to inclusiveness as a political value, whereas the best chance of showing effects would probably have been to focus continually on a more limited audience. The original target audience in the first year, males aged 18 to 34, reflected the primary social location of heavy drinking in American society. The State office decided to expand target audiences for the subsequent years, adding professional women in the second year and teenagers in the third year. A federally funded and separately run Hispanic program, operating in the same target areas and under a Spanish translation of the same general media slogan as the State project, complicated the question of what exactly was being evaluated (see Caetano 1982).

- The community component consisted primarily of 2-hour didactic sessions presented by paid staff of the project's community component. Audiences were primarily recruited by nonprofit organizations, particularly churches, which were paid on a per capita basis for recruiting audiences for the sessions. In the third year of the project, the primary emphasis was shifted to "mass contact strategies which would familiarize people with the campaign and its slogans" (Wallack and Barrows 1981, p. 31). In the absence of a commitment to any clear community-action model, the strategy of the contractor chosen for the community-action component was oriented toward one-directional educational dissemination, which was unlikely to cause either trouble or change.

- Although the original aim of the demonstration was "to form a basis for an eventual statewide implementation," by the end of the project, the State had more or less lost interest in any further development in the same line. The responsible staff at the State level, including the director of the Office of Alcoholism, had changed in the course of the project. "Rightly or wrongly, various people associated with the demonstration felt that the program was no longer supported by the State after the Governor had intervened in the first year" (Wallack and Barrows 1981, p. 175). The basically negative results of the evaluation were accepted without much complaint. The evaluation was little noted outside a specialized academic audience.
- Despite the decentralized organization of the project, the evaluation by its very existence tended to influence what went on in the program. Discussions of the content of the first survey instrument became a means of focusing the attention of participants on setting concrete goals. By the third year of the study, the community action component had adopted as its de facto aim increasing the visibility of the project, with the goal of increasing the percentage of the evaluation sample who had heard of the project.
- The most politicized aspect of the evaluation was how the politicization of the project itself was to be reported. Long negotiations went on between the evaluation staff and the State agency about the acceptable formula for reporting the Governor's intervention, although it had been widely reported in the media, in the evaluation reports.

Federal Prevention Demonstration Grants for Community Action

NIAAA's commitment to strongly evaluated prevention demonstration grants at the community level arose in part out of a debacle and in part out of a process of development. The debacle was the result of NIAAA's first grants in the prevention area, in 1974–75, when a sudden release of impounded appropriations was used to fund grants for alcohol programs in national organizations such the Jaycees, the Boys' Clubs, and the League of Cities-Conference of Mayors. At the request of a Congressional committee "distressed" by what was seen as an inappropriate use of grant funds for constituency-building, NIAAA completed a critical internal review in late 1976 that promised to align grant review procedures in the prevention area with "the formal peer review process utilized for other institute programs of a more traditional and well-defined nature in the training and research areas" (Lewis 1982). When NIAAA funded new grants in the prevention area in late 1977, after a hiatus of 2 years, they were as demonstration grants: grants primarily to community-level agencies, justified as a Federal expenditure in terms of their potential as a test and demonstration of new approaches or techniques, and thus with a required evaluation component (Wittman 1982).

The process of development reflected an unusual interaction in the late 1970s between the NIAAA Prevention Division staff and its consultants, who also functioned for several years as an ad hoc peer review panel for the Division's grant proposals. Particularly in the wake of a workshop involving the staff and consultants in late 1976, the consultants brought to the Institute staff the expanded prevention agenda that was implied by the shift from a concern only with alcoholism to one with the whole range of alcohol-related problems (Room and Sheffield 1976). The Division began actively to solicit proposals extending beyond the overwhelming concentration on educational or service organization projects for youth in its grant submission pool. By 1979, knowledge development took clear precedence over service provision in the Division's description of what it was seeking in a grant proposal:

> The objective of the Alcohol Abuse Prevention Demonstration Grant Program is to support projects that test specific hypotheses about current and new approaches aimed at minimizing the occurrence of alcohol-related problems through means other than treatment or rehabilitation services. Since the aim of the grant program is to *test* methods, strategies and approaches, rather than to provide direct prevention *services*, support for such services will be provided only in those cases where it is essential to the demonstration purposes. All proposed projects must include a clear hypothesis, a well-designed methodology, and an effective evaluation plan (quoted in Wittman 1982).

In 1979, the Division also embarked on a project to test the replicability to other sites of what were seen as three successful and potentially disseminable projects (only one of these, a campus project at the University of Massachusetts, might be regarded as a community action project). A contractor embarked on the task of providing an evaluation of the project as a whole.

NIAAA's Prevention Division, its work, and its key staff were swept away as part of the block-grant demarche of the early Reagan administration. Starting in 1987, NIAAA again set up a Prevention Branch focused on prevention research, but thus far without a demonstration grant program and with little emphasis on community action approaches. In the meantime the 1986 Federal drug act set up a program of demonstration grants through the new Office of

Substance Abuse Prevention (OSAP). Demonstration programs have become fairly common in U.S. health policymaking: A recent article comments that "the 1980s seem to have become the 'decade of demonstrations' for federal health policy" (Scheslinger 1988).

The OSAP program seems to be recapitulating the history of the NIAAA Prevention Demonstration grant program. An initial flurry of funding in a politicized situation put a premium on committing large sums of money as soon as possible, with little effective attention paid to the demonstration quality of the grants. An assessment for Congress by the General Accounting Office has documented the lack of effective preparation for useful evaluation of the early grants under the 1986 act (U.S. General Accounting Office 1987). Current unpublished documentation from OSAP on the "current status and planned activities" of the OSAP Demonstration Grant Program reports that "OSAP's approach has been to recognize the difficulties of conducting controlled prevention evaluation research, and to support efforts to move the field toward empirically-based tests of promising prevention programs." Plans are to "increase the evaluation requirements in new grant announcements, and build monitoring and evaluation systems into newly awarded grants from the onset of their awards." "Replication trials of promising programs" are envisaged (OSAP 1989).

Some lessons of a prevention demonstration grant program. My connection with NIAAA's Prevention Division began with a paper on "The Minimization of Alcohol Problems" prepared for an NIAAA conference in 1974 (Room 1974). In 1976 I was added to the Division's ad hoc review panel, and for the next several years I served both as a grant reviewer and as an advisor to the Division. My comments are mostly based on my experience as a reviewer.

- A demonstration grant requires both a sound program and a competent evaluation, and to put these together in the same proposal proved quite difficult. Throughout the late 1970s only 10 to 20 percent of the applications for the demonstration grant program were approved, a considerably lower percentage than for straight research grants.
- A strong value tended to be placed on innovativeness in the program to be evaluated. Partly this trend reflected the idea that if the program was not innovative, the project was not really scientific. But it also drew on more general cultural perceptions that it takes brand new ideas to bring about social change. It proved to be very difficult to argue successfully that a sound evaluation of a run-of-the-mill program, reflecting everyday practice, might be a strong contribution to useful knowledge. I continue to argue that we often learn more from evaluations of unsuccessful programs than we do from evaluations of successful ones, and that an evaluation of a one-of-a-kind intensive program in a highly academic environment may not teach us much that we can use.

- After several years of experience, the Division staff and consultants began to build up a record of experience, but this knowledge remained relatively esoteric. For instance, "alternative programs" were concluded to be highly politically popular in the target community but were unlikely to impact on alcohol use or problems. We summed it up with a quote from Klaus Mäkelä, "the trouble with alternatives to drinking is that drinking combines so well with so many of them." This conclusion was reported to have been strongly challenged by staff at the National Institute on Drug Abuse (NIDA), which was then strongly committed to an alternatives approach. The Napa project was funded by NIDA to demonstrate that nondrug-specific strategies would affect school children's drug use. To the credit of the Napa project staff, they eventually reported that, in large measure, our conclusion also applied to nondrug-specific prevention programs (e.g., Schaps et al. 1984).

- As the insistence of a strong evaluation took hold in the NIAAA grants program, the strength of the prevention intervention component in the grant proposals tended to weaken. Projects were increasingly based in academic rather than community agencies, and the prevention intervention tended to be a professionalized delivery of educational or other services, sometimes on an individual basis. Somewhat controversially, some members of the review panel began to use the cost per person affected as a criterion, lowering the priority of projects with a high per capita cost on the grounds that they were unlikely to be disseminable even if successful. Panel members sometimes speculated that it would be cheaper and perhaps more effective simply to pay teenagers not to drink than to carry out some of the proposed prevention programs.

- Few of the projects were community action projects. Almost all of the projects that were community action projects involved change agents from outside the community or professional services provided to the community. Any community action project seeking change from inside the community was likely to be explicitly political in its approach, and thus inappropriate for Federal Government funding, and was likely to resist the program compromises and the disinterested perspectives inherent in allowing a good evaluation of its activities. As one example, although the parents' groups movement against teenage drug use had a substantial effect on U.S. drug policies, and took on semi-official status with NIDA (Manatt 1983), the only evaluation of the effects of parents' groups on their communities was conducted retrospectively and had to rely on incomplete archival data to measure the effects of teenage drug use (Moskowitz 1985). Forming an alliance with an evaluator and applying for Federal funding is an unlikely way to start a social movement seeking real change.

- The shift toward requiring stronger evaluations in the demonstration grants partly reflected the premium on research activities in NIAAA's institutional environment, but it also functioned as a defensible device when making hard choices between the multitude of communities that would seek Federal resources for activities related to preventing alcohol problems. In that sense a demonstration program allowed allocating governmental resources to only a few communities rather than to the whole polity. As the evaluation requirements became more stringent, the demonstration program's constituency of political support became smaller. The history of the NIAAA program may thus fall into a repeated pattern: starting with loose requirements and an encouragement of a broad range of applicants, tightening the evaluation requirements in part as a way of choosing between applicants, and ending up without a political base to offer effective resistance to its dismantling.[1]

An Unstable Mixture: How Does It Come About?

Evaluated community action projects involve an inherently unstable mixture of two and usually three mismatched frames of reference and agendas: those of the community members, those of the change agent, and those of the researcher/evaluator. The change agent usually brings a professional or organizational perspective to bear and often operates within institutional constraints about what are appropriate or desirable actions to be undertaken. The change agent's field of vision often extends beyond the parochial concerns of community members.

On the other hand, change agents usually operate in terms of a relatively narrow segmental agenda. In particular, they are usually expected to stimulate or support actions that will have a direct relevance to reducing alcohol problems. Community members may have very different priorities, and the two agendas may not overlap. Community organizers in projects in our field usually do not have the freedom to follow Saul Alinsky's advice: start out with the issues that most concern local folk, no matter how they are defined.

To be any good at the job, change agents have to believe passionately in what they are doing. On the other hand, the evaluator needs to be skeptical. At a minimum, even if the evaluator believes in the efficacy of what is to be done, that person has not only to allow for the possibility the belief is falsely based, but also diligently has to search for, measure, and report negative evidence. Frequently the evaluator becomes defined as a nuisance quite early by insisting on knowing beforehand what would constitute success or failure for the project.

The evaluator's perspective also often clashes with that of the community member. One of the classics of the health education evaluation literature is a rueful and insightful analysis of why the evaluators were ridden out of a Canadian prairie town (Cumming and Cumming 1957). The evaluator's interest is to document for the outside world and for posterity what went on in the course of the project, and usually the evaluator is paid by and responsible to an outside constituency. But the documentation may not be entirely welcome; the community member may find the evaluator's picture of the community unrecognizable, and the publication may bring unwanted attention to community processes. The functions of such processes in the community—functions that could be described as latent only in terms of that officially recognized knowledge—often differ from their official, manifest functions. The continuance of these functions may be threatened by the exposure to scrutiny the evaluator brings.

What brings together this unstable mixture? Sometimes communities find themselves the target of a project with little warning and little motivation on their part. Some community members may want the professional services, training, validation, or attention the project might bring. Often the community's interest has been in outside funding for services that the study, as a demonstration project, may entail. Rarely is the community interested enough in the evaluation to pay for it. Evaluation is usually something funded by and done for the outside world.

From the change agent's perspective, the evaluation may be a necessary nuisance: The demonstration project cannot be funded without an evaluation component. In other cases the change agent works in, is responsible to, or gains status from a connection to a research or academic environment. In this case the change agent may also do the evaluation.

The pressure for a formal evaluation of community action projects is a relatively recent innovation, dating back no later than the mid-1960s in the United States. The pressure derives mostly from two sources. One source of pressure is from higher levels of Government—National, State, or Provincial—when they are supporting the community action. For the funding agency, the evaluation may serve several purposes. The evaluation is a monitoring device for assessing how well the Government's money is being used. A rationale is provided for central government funding of activities in one place rather than another; that is, the project is a demonstration project, designed to develop replicable knowledge and programs. Often it has also been a badge of modernity and openness: Project evaluation is something a truly up-to-date Government agency ought to be doing. Last, for an agency postponing dealing with a difficult political problem or providing funding for a program with universal coverage, launching a demonstration project may gain as much as 5 years' respite.

Another source of pressure derives from the academic aspirations of particular professions. A program involving a behavioral psychologist or a health educator as change agent is probably far more likely to have some sort of evaluation than one involving a nurse or a lawyer. Evaluations have become part of the armamentarium of some professions heavily based in academia. This situation is a major reason that the best-evaluated strategies are usually not those actually in everyday frequent use (as has been noted for alcohol treatment modalities). Academic disciplines with a commitment to evaluation tend not to control the decisions about the nature of everyday activities. And the academic commitment to the new and novel points away from evaluations of commonplace actions or processes, although such evaluations might have far more policy significance.

In many projects the same person fills two or more of the roles we have been discussing—community member and change agent or change agent and evaluator. Given their different perspectives, inherent conflicts exist between these roles. Usually one role or the other will take priority in situations of conflict. While there are certainly honorable cases of change agents who fervently believed in their work but found it, on evaluation, to have been ineffective or wrongheaded, there are other instances of investigators in this dual role where our kindest conclusion would be that they put the best face on the results in what they chose to report. Negative findings are probably more often published by change agents who went into the project with some skepticism; this attitude may, of course, have hampered their effectiveness as a change agent. All in all, combining the roles of change agent and evaluator is questionable.

On the other hand, too much organizational separation between the change agents and the evaluators can also create difficulties. Certainly one problem with the California Prevention Demonstration Program was the State's decision to contract separately for a media program, for a community action program, and for an evaluation, with occasional coordinating meetings as the main connection between the three efforts.

Bringing an evaluated community action project to fruition is difficult and time consuming, particularly in the field of alcohol problems, where strong preferences, moral concerns, and economic interests are at stake. We need to shift norms of scholarship and publication so that negative outcome findings are seen as equally as important and interesting as positive findings. Even more urgently, we need to provide channels by which what was learned in the process of the project can be broadly disseminated in a lasting form. We hope that the substance of this monograph is a step in this direction.

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Notes

1. NIAAA's new program of Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals has from the start had strong requirements for evaluation, both within individual grants and for the demonstration program as a whole. See *Synopses of Community Demonstration Grant Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals*, Rockville, Md.: NIAAA, 1988.

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CHAPTER 2

Conceptual Issues

Perspectives on the Community in Action Research

Harold Holder and Norman Giesbrecht

Introduction

Efforts to prevent alcohol and other drug-related problems at the community level are predominately oriented toward individuals (Terris 1968; Eisenberg 1977; Schaps et al. 1981; Wallack 1984). Typically, initiatives focus on (a) identifying those individuals who are "at risk," (b) determining the nature of the risk, and/or (c) modifying the knowledge, attitudes, and/or behaviors of those people at risk. Thus, despite increasing reference in the literature over recent decades to society, culture, institutions, and communities being the foci of prevention initiatives (e.g. Orlandi 1986; Edwards and Edwards 1988), our actions are still primarily directed at individuals (Holder and Wallack 1986). Researchers have paid less attention to the social circumstances and environmental conditions that tend, for example, to promote drinking or drug-taking or to increase the likelihood of undesirable consequences arising from consumption, than to the characteristics and behaviors of alcohol drinkers and drug-takers. It remains to be demonstrated, however, that it is more effective to target the individual than to change the conditions and contexts in which problematic behavior emerges.

It is curious that behavior such as alcohol or drug use, which is highly social, organized in groups, typically takes place in institutional contexts, and has strong cultural restraints and inducements, is usually confronted through prevention programs that focus on the individual. This seems to be a weak response to a highly diverse and broadly based phenomena.

One might expect a prevention tradition that displays stronger links to community organization and development, political activity and social reform in the work place, and urban change and enfranchisement of the powerless—in other words, a tradition that draws from the broader experiences of community transformation, mobilization, and development. Instead, the key influences in prevention appear to be from the specialists in disciplines where the individual is the key focus — for example, medicine, psychology, social work, and education. The contributions of economics, epidemiology, political science, social anthropology, sociology, and urban planning have not been as extensive in developing and focusing prevention efforts as they might have been. An orientation toward the individual tends to place the intervention as a primary independent variable rather than focusing on the interactions among three generic variables—the population, the environment, and the prevention effort. In many prevention initiatives, the person or collection of persons is presented as a passive recipient of the program. A series of similar interventions are undertaken on a series of persons and the sum total is expected to provide the basis for community change. This is really a variation of a treatment model, with (instead of treatment) education, correction, or persuasion being offered to, or foisted upon, a target group, in a manner similar to treatment of the dependent alcoholic or drug user.

These interventions are neither irrelevant nor inappropriate. However, in light of the social nature of most alcohol and drug use (Skog 1980) and the distribution of problems and victims, they are incomplete. Discouraging persons from doing something or encouraging them to do something else is not the same as modifying the conditions in which the undesirable practices take place. The two initiatives may be complementary, but they are not adequate substitutes for each other.

Social and cultural environments, political systems, demographic structure, and industrial and economic conditions are legitimate foci of prevention initiatives; they are not merely the sum of habits, views, behaviors or experiences of individuals, nor a static backdrop for the front-stage interaction of genetic, psychodynamic, familial, or small-group forces. The central goal of prevention initiatives that have drawn from this research tradition is therefore to modify social and economic patterns of alcohol and other drug use. In the case of alcohol, for instance, interest has risen in recent decades among some researchers in a broader orientation to alcohol problems, focusing on the possible benefits of various control measures such as laws, regulations, and policies regarding the sale of alcohol (Bruun et al. 1975; Popham et al. 1975; Room and Sheffield 1976; Mäkelä et al. 1981; Single et al. 1981; Moore and Gerstein 1981; Holder 1987).

We propose that community prevention requires adapting to the social context and environment in which alcohol and drug problems occur and facilitating modifications in that larger context and environment. Effective prevention eventually involves directing attention to various foci, including the individual, social groups, and institutions. Furthermore, as Morgan (1988) and others have demonstrated, the alcohol beverage industry has developed considerable expertise in deploying multi-level strategies to promote its interests and products; tactics are directed not only at the consumer, but also at distribution and service networks, governments, and even treatment and prevention organizations. When the issue is drinking-related problems, however, these same industries tend to promote an image of personal responsibility that blames the individual drinker for his or her problems. Such a view is both incomplete and inadequate, and serves to direct attention away from the producers to the consumers of alcohol. To combat such influences, coordinated multi-level strategies need to be developed to prevent alcohol and drug-related problems.

Since the early 1970s, there has been a growing interest in more system-oriented approaches, including encouraging community responsibility for drinking problems, mobilizing local efforts in shaping an environment, and focusing on environmental issues, politics, and structure, instead of only on those persons who drink to excess (Holder and Wallack 1986). The purpose of this paper is, therefore, to consider the nature of communities in the context of alcohol and other drug prevention as an aid to planning and implementing multi-component and multi-level prevention interventions.

The Nature of Communities[1]

Official public action to prevent problems related to alcohol and other drug consumption has often been based upon idiosyncratic preference and beliefs (Orcutt and Cairl 1979). While such approaches are usually popular and easily appreciated by both the public and the government, many have, at best, only modest success. Such poor performance is partly the result of an underdeveloped technology for prevention: we just do not have very firm evidence as to what works. In addition, we lack an adequate understanding of communities.

Our understanding of communities is constrained by simplistic conceptualizations and models, as well as inadequate data, particularly with regard to understanding alcohol and other drug-related issues and their sequelae. In designing prevention strategies, we need to bear in mind that communities defy simple description; they are dynamic, complex, differ in important ways, interact with prevention programs, and function in ways that may be counterintuitive.

Communities Are Dynamic

Communities are not static entities but rather are in constant flux. Prevention programs should have mechanisms to sense and adjust to community change; rigid intervention protocols or strategies can easily become out-of-line with changing community issues, agendas, or power arrangements. Community dynamics are less likely to be a serious challenge in short-term interventions, although such initiatives are less likely, on balance, to have robust impact. Alternatively, longer interventions will afford an interplay with community dynamics, but developments, in turn, will likely confound conventional evaluation of the impacts of the intervention. For example, whatever overall impacts emerged from the classic North Karelia project to reduce the rates of cardiovascular mortality and morbidity in a county in Finland (Puska et al. 1980), the range, scope, and modifications in the intervention components challenge our understanding of critical features of the overall experience. In short, community dynamics must be accommodated in the design of prevention initiatives in order to evaluate the effect of the intervention. It is problematic to assess impact in dynamic situations with evaluation techniques designed for static contexts. Prevention workers involved in action research may be more in tune with dynamic situations and responses to community interactions, responses, and processes; whereas researchers concerned with evaluation standards and outcomes may have to learn to make modifications in their orientation in order to accommodate changes in the study site during the course of a project.

Communities Are Complex

In developing our skills in community-based prevention, we need to ask questions about numerous social factors. For instance, what are the local values and norms concerning the use of alcohol or other drugs, such as the traditions and practices influencing the places, occasions, times, and events in which drinking or other drug use occurs? How do socioeconomic factors, including the availability of products or substances and consumer purchasing power, affect substance use? How do community leaders and other elites shape mores about consumption? What groups or institutions benefit from alcohol consumption and the market for illicit drugs? How do a community's cultural history, tradition, and rituals shape the context of substance use? How have law enforcement and other agencies such as social and health services responded in the past to drinking or drug-use events or problems? These are just some of the questions to take into consideration. In addition, there are also factors that are not, strictly speaking, within the potential influence of community prevention efforts, but that can nevertheless affect substance use. These factors might include employment levels and overall disposable income, density of housing and living conditions, and the levels and traditions of law enforcement and compliance with the law by community residents.

Furthermore, the level and type of institutional resources will play a key role in facilitating prevention initiatives, including the interest, organization, and agendas of voluntary and government bodies that take on alcohol/drug issues (Room 1980). In addition to complexity at the structural or organizational levels, one is also faced with variations in ideological perspectives, cultural lore, perceptions of previous efforts to change local practices, and the views, agendas, and level of interest of key individuals. To understand the characteristics of a particular community in terms of some of the factors just outlined, researchers need to engage in dialogue with community respresentatives before and during prevention initiatives.

Communities Involve Feedback

A natural extension of the complex and dynamic nature of communities is feedback or interaction between prevention projects and the community in which it is undertaken. In its simplest form, feedback can be described as Factor A influencing Factors B, C, and D at time t, which can in turn be influenced by any one of these factors at some later time t+1, t+2, ..., t+n. In such a feedback loop, actions taken can be affected by reactions to these same actions. For example, econometric research suggests that increased taxes on alcohol can contribute to lower consumption, particularly heavy, high-risk consumption (Bruun et al. 1975; Cook 1987). If demand falls, marketing and production of such beverages should theoretically also fall over time. If marketing and production fall, then supply and demand can potentially also continue to decline. Thus, a negative feedback loop has altered both availability and the consumption of alcohol over time.

In another example, if efforts to decrease the supply of illicit drugs such as cocaine are effective, they can drive up the price of such drugs and thus attract others into the business because of higher profits, assuming demand remains the same. In this way, total supply can actually be increased. If this increased supply stimulates greater enforcement, prices can go even higher and the economic attractiveness is increased, etc. This illustrates a positive feedback loop.

The community prevention researcher is faced with a dynamic and complex system with numerous feedback loops and connections. Since it is impossible to isolate target groups for community interventions, efforts to produce changes in one group of substance users will likely be met with a mixture of support, disinterest, and resistance, depending on how the intiative affects the environment of other users. For instance, substantially reducing consumption among heavy drinking adult males can disrupt established social and economic practices in a community. This may be one factor in the relative imbalance between, on the one hand, the substantial contribution of this sector of the population to the overall load of problems, and on the other hand, the limited resources ear-marked for specialized interventions (Giesbrecht and Conroy 1987).

Typically, what is brought to complex community systems is a simple linear intervention protocol, involving a few components primarily oriented to modifying the behavior of the heavier and heaviest consumers through educational, persuasive, regulatory, or punishment techniques. The prevention protocol may not account for a number of important factors in the community and any interaction among various interests and political forces with the result that the prevention strategy is unable to produce a significant change in the target behavior or its spinoffs.

Communities Are Counterintuitive

Another natural extension of the complexity of communities is the frequent tendency of community-based actions to run counter to our expectations or intuition. This means that like all complex, dynamic systems involving feedback, simple static models based upon direct personal experience can lead to erroneous expectations of problem reduction.

Historical reliance upon school-based education to prevent or curtail alcohol and other drug use illustrates the inadequacy of a simple direct model. According to this model, if children are told about the dangers of alcohol and drugs, they will then tend not to use them. Controlled evaluation of such programs has shown little success in reducing consumption in the long run (Goodstadt 1978; Moskowitz 1979). If we note that the use of alcohol or other drugs by young people is a function of availability, the social values assigned to its use among one's peers and social group, and its relative price, we may begin to grasp why formal information-based programs have limited impact. Similarly, if chilled beer is readily available to underage young people at convenience stores or is readily provided by adults (including young adults just over the legal age of purchase), these practices will likely limit the potential impact of an alcohol education program on reducing consumption among young people.

Simple models of the community—based on personal experiences of prevention planners—can lead us into a counterintuitive trap. While some life situations function as direct stimulus-response or push-pull relationships, such a model may not apply to social life and its application may lead us to design prevention initiatives that are ineffective and even harmful.

Communities Differ on Key Features

While some generalizations may be drawn about communities of a certain size, economic base, regional location, and ethnic or demographic composition, we nevertheless find rather dramatic differences among some variables such as the rate of alcohol consumption. County data for Ontario, for example, indicate considerable variation in the 1985-86 annual rate of absolute alcohol sales per adult, ranging from 7.2 to 18.1 liters, or a maximum that is 2.5 times greater than the minimum (Rush 1987). Town-specific data also illustrate marked differences in the rate of alcohol sales. A few decades ago it was assumed that the larger urban centers in North America had higher rates of alcohol consumption and drinking-related damage but recent data no longer fully support this generalization. It is not only newer primary industry boom towns that have been found to have higher rates of drinking per capita (Giesbrecht and Macdonald 1982); other traditional towns have also been found to be locales of atypical heavy consumption (Giesbrecht and Conroy 1987).

It would appear that a number of features have an influence on the rate of drinking in a community. These include such factors as:

- the age structure (with younger people drinking more and those of retirement age drinking less);
- the male-to-female ratio (males tend to drink more, but female consumption has been increasing);
- the availability of alcohol (the real price of alcohol, the number and type of outlets, hours of sale, distribution and serving practices);
- the purchasing power of the average consumer (the proportion working, average wage, and take-home pay);
- the strength of the drinking culture (informal and formal rituals, groups, associations, and the range of routine occasions that involve drinking and heavy drinking);
- the prevalence of alternative leisure and recreational activities that are not integrated with drinking;
- the strength of abstinence perspectives in the community; and,
- the effectiveness of regulatory and related measures in impacting the location and operation of outlets, minimum purchasing age, and serving practices.

Community differences with regard to other features, such as the size and orientations of the hospitality industry, the law enforcement and justice institutions, health and social services, and educational institutions, also bear on the experiences and outcomes of prevention initiatives.

These differences illustrate the difficulty in directly transfering experiences from one community to the next. Since duplication of procedures and outcomes is extremely difficult and rare in action projects in natural settings, perhaps it is necessary to be more modest about the generalizability of programs and interventions.

Communities Are Outside Our Experience: Need for Models

It is beyond our sensory capability to experience directly a total community and thus we need abstractions or representations. In order to enhance the effectiveness of prevention programs, adequate models of the community are required. We propose that such models incorporate properties such as those outlined above in order to increase our understanding of complex social systems. Such models have a number of useful aspects:

(1) They can be used to evaluate our current level of understanding of a community system, i.e., can be used to recreate history, for example. Actually, model testing is an assessment of the social scientist's ability to recreate a complex community system.

(2) In addition, models provide a means to identify and describe important features of a community.

(3) Models force us to make decisions about relationships or at least empirically examine assumptions. In fact, a model is a useful basis for identifying research needs and priorities about communities.

(4) Models can be used to make predictions about the future using a variety of assumptions. A key quesion will be, what are the likely patterns and levels of community alcohol and other drug problems which follow from each assumption?

(5) Models can be used to undertake experiments about potential community prevention interventions and thus to make projections about likely outcomes. Such simulations can be an aid to program and policy planning.

Based on research and experience, we can start building models of communities that incorporate important community factors and how they are interrelated using drawings and diagrams. Such drawings are an excellent first step to identify those community elements that cause concern and to incorporate available information. Mathematics and computer languages may provide additional tools to develop and test models of communities (see Katzper et al. 1976; Holder and Blose 1983, 1987, 1988).

Implications

Bringing the community into the center of the prevention picture has a number of implications. Five are noted here.

Increased Planning

In considering the nature of a particular community, the prevention worker or action researcher is facèd with a dilemma, namely, the ongoing tension between taking stock and doing. The situation is not unlike that of the politician who, in trying to figure out how to present his/her views, or even what they should be, takes too much (or too little) time in finding out what the voters want, and in the end is either early with an inappropriate message or late with a potentially winning agenda.

In light of the issues discussed, we envisage a stock-taking and community development period of a year or longer, followed by planning and then by implementation of prevention programs. Nevertheless, in the interim, opportunities to implement a prevention program may have passed, or funds shifted elsewhere. Local tragedies, such as deaths after a high school graduation, unfortunately are often a key basis for community mobilization against heavy drinking and risk-taking (Holder and Hallen 1984).

Training and planning sessions with key local personnel are useful for efficiently accomplishing the two related tasks of taking stock of the community and mobilizing interest. Local people from a wide variety of backgrounds and having a potential to influence alcohol/drug policies might be asked to participate in workshops or planning meetings. During these sessions the prevention facilitators provide generic information about alcohol/drug issues, levels of problems, and intervention options, and the group develops a sense of what is feasible in the context of local dynamics and interests, then selects and operationalizes strategies. Experiences in San Francisco, California (Wallack 1985; see papers by Wittman in this volume) and Thunder Bay, Ontario (Douglas 1986, also his paper in this volume) support this approach.

Decentralization

Planning, development, and implementation will likely become more localized, even if some of the intervention models, tools, and materials are developed centrally. Community-level prevention is by definition locally focused; therefore, the intervention requires an understanding of local factors and arrangements and the character of the community. The primary responsibility and motivation for prevention is also likely to be local.

Respecialization

We expect that a community focus in prevention will enhance the desirability of local expertise in community planning, development, and politics for those in the prevention field, which may in turn lead to new strains between community workers and evaluators, or between those oriented to one-on-one prevention activities. Specialization could also lead to innovative resolution of these strains.

Reintegration

Community-oriented prevention could lead to a close examination of the relationships (both confounding and reinforcing) of various local efforts in combating alcohol and drug problems. Noble efforts and good intentions are insufficient to address these problems; coordination of local efforts is required. It would appear that local planning that is both cognizant of issues and the interplay of various efforts and agendas would be a step toward reintegration and reinforcement (Giesbrecht and Conroy 1987).

Reorientation of Goals and Strategies

Finally, by focusing on the community we expect that certain goals and strategies may take a more prominent place than has been the case in the last few decades. Aggregate rates of consumption or problems, modifications of laws and regulations, transformations of selling procedures and arrangements, increased political prominence of alcohol issues on local agendas, and so on are the sort of yardsticks that might be used to measure the impacts, thus effectively raising the stakes to demonstrate a program impact. This development is changing the dynamics of the prevention projects in at least three respects. First, longer term and more robust community-level prevention is required to modify, for example, overall rates of consumption, than is needed to modify the behavior of a small subset of the drinking population. Second, changes in the dominant social, economic, and environmental structure that determine how alcohol or drugs are used are likely to have filter-down implications. Third, strategies with different orientations or targets will need to become complementary. The following would benefit from stock-taking at the community level as to their mutually reinforcing potential: (a) policy initiatives, (b) educational programs or mass media campaigns, and (c) advice, counseling, or correctional programs directed at the individuals who drink heavily.

Concluding Remarks

If the community is the point of reference, responsibility for drinking or drug-taking related complications can be seen as more widely distributed. The more conventional orientation focusing on the individual allows for loading blame and diffusing responsibility. The notion that "normal" local practices and mores may contribute to incidents will not be popular.

The complexity and dynamics of a community make it difficult to design and effectively implement "quick fix" prevention interventions. Effective changes in community systems take time to produce long-term reductions in alcohol and other drug problems. Community members and political leaders often expect short-term effects and therefore lose interest in prevention efforts that take time to implement and even longer to reduce problems or high-risk behavior.

The technology and understanding of community systems are still underdeveloped. Reliable and valid models of communities are required to increase our understanding as well as our ability to develop effective prevention strategies. In turn, we require a greater interest in and scientific understanding of complex social arrangements such as those that involve alcohol misuse and other drug use.

Recognition of the need for better understanding and better models of community systems should lead us to be cautious about designing simple interventions. This caution can properly encourage us to (a) develop long-term baselines for prevention targets, (b) carefully identify the points of intervention in the community most likely to yield desired change, and (c) monitor the community over a sufficient long-term period to determine if real change resulting from the community interventions has occurred.

Prevention involves taking risks and making choices about the key targets of the intervention, the methods and strategies to be used, and balancing of different components in order to enhance the overall impact. Risks and difficult choices are involved because the information is often inadequate, the research points to divergent conclusions, or the research is too narrowly focused on specific topics to allow us to address questions about multi-level interventions. Risks are also involved since the orientations required may diverge from vested interests or established routines for dealing with alcohol and other drug problems.

Nevertheless, we believe that the benefits outweigh the risks, and exploring community-based alternatives has the potential to enhance prevention efforts.

Notes

1. In this paper the community is pervceived as a geographical-political entity. Other working definitions are of course appropriate and relevant for prevention enterprises. The reader is referred to the paper by Pederson et al., in this collection, for another discussion on this topic.

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Democracy and Community Action Programs

Stig Larsson

Every community action project has political and ethical implications. This is especially true of planned community actions in the field of public health and social welfare when these actions involve questions of lifestyle and interpersonal relations. For that reason, it is of particular interest to consider community action programs (above all, those concerning the reduction of alcohol consumption) from the perspectives of democracy and ethics.

This article arises from experiences and reflections during the period of planning and initiating a community action program to prevent alcohol-related problems in the Kirseberg district of the city of Malmö, Sweden (see later in this volume). In Sweden, as in other parts of Scandinavia, there is an ongoing debate about how to create new approaches to increase community participation in democratic structures. There is also widespread concern and criticism of various actions that are seen as manipulating inhabitants.

During the last decade, a discussion has surfaced on the issue of how one can reduce the ever-present bureaucratic structure while increasing citizen participation in community development. Among several of the earliest democratic theoreticians, such as Rousseau, can be found an implicit assumption that democratic government would enhance and activate citizen participation in the operation of a society. This is quite explicitly expressed in the writing of John Stuart Mill, who saw democracy as the means of educating the public en masse, despite his emphasis on a core intellectual elite and its importance in producing democracy (Schmandt 1963).

Some perspectives of Marxism include the view of individuals as active products of society. Actualization is brought about through democratic participation (not just voting in yearly elections) within the larger social structure. Marx uses the term *executive democracy* as a representation of the highest form of public democracy, which seems to mean that citizens should be included in the organization of relevant programs. (An example is the older Swedish history of broad participation of citizens in the administration of the small communities.)

In modern social research, the actual ability to participate in the public arena has been systematically researched in several ways. Sten Johansson (1971) has come up with the term *political resources*, referring to the possibility of making the political voice of each individual heard. Stein Rokkan (1970) divides the political development of human rights into three stages: the *formal realization*; *mobilization* (when those less active begin to use their political rights); and *activation* (representing the competition between various groups and their beliefs in the public arena).

In Sweden, the issue of what Alf Ross (1952) calls the "extensivity" of democracy arises in connection with the drastic reduction in numbers of more locally responsive politicians in a politically centralized society. This centralization has weakened a number of attempts to reorganize local community institutions. In a related vein, a discussion has grown around the antagonism between the professional and the "citizen amateur," particularly in social work, health care, and social welfare. Various social agencies systematically have attempted to put into practice social psychological theories with the aim of increasing democratic participation for those individuals considered weak on the political resource scale. Nevertheless, in view of the fundamental role ethics and democracy play in the success and design of community action research programs, it is surprising that greater attention has not been given to these dimensions (Crawford 1977).

The Kirseberg Project is a part of the action research tradition as formulated, among others, by Kurt Lewin (1948). The project was initiated by researchers, but its development included the local population, as well as local authorities (e.g., primary health institutions, schools, and social welfare agencies) as participants. This paper analyzes various views of the democratic ideal and lists examples of how the Kirseberg Project has been confronted with several democratic contradictions. Although the list is incomplete, its purpose is to give a short account of the problems connected with planning and implementing community action programs from the perspective of democratic participation. This article also discusses the relationship of these principles to our model of change and our plans to study effect and process.

In community action projects, there are built-in dilemmas, which appear as a latent result of changes initiated by professionals. These dilemmas can be better represented in terms of dichotomies.

Professionalism Versus Amateurism

This dimension was present in planning the project. Some of the questions we have raised in this context are as follows: How and under which circumstances might the initiative be transformed from the professionals to activists among the population? What effects will be generated from different ways of transferring the responsibility to the local population, for intervention as well as research?

Expert Knowledge Versus General Public Opinion

This contradiction is probably more visible in the field of alcohol use than in most other areas. Simply put, the experts know that it is injurious to drink alcoholic beverages, while general, public opinion holds that one may use alcoholic beverages without abusing them. A great deal of our initial effort has been spent analyzing the question: What is a reasonable message of the experts to the population—what might be positively received, and what would be helpful to decrease the alcohol consumption in the community? And who are the real alcohol experts? In this context, we have been aware of the latent conflict between medicine and social science, as well as the administrative conflict between health care and the social welfare administration.

Central Power Versus Periphery of Power

This dichotomy has been present in our work in many ways. The success of our work is highly dependent on the central economic resources available for the project. Therefore, the program was implemented on both national and local levels. In addition, evaluation of the program is complicated by the different levels of intervention. How is it possible, for example, to separate the effects of Government efforts from the effects of the local work of the project? What power structure is responsible for results?

Pyramid Versus Bottom-to-Top Power Structure

In democratic theory, the assumption is that all power comes from the people. It is obvious that this simple model is not applicable to most community action projects—and hence, not to this one. An important question is, What kind of organizational structure should be created? It should be as close as possible to the original democratic model and at the same time guarantee the possibility of action in fulfilling the intentions of the project. Without a satisfying solution to this dimension, many action research projects risk being stranded. The contradiction between central and local interests is often resolved when the stronger, central power terminates the weaker, local activity by withdrawing economic and personnel resources.

Population as Object Versus Subject

The question of how the base of power in community action projects is set indicates whether the population is seen as object or as subject. In the Kirseberg Project, the initiative came from outside. This circumstance implies an object-relation to the population. Our efforts, therefore, have been dedicated to anchoring the project deeper in the population and its organizations. Without local acceptance, the project would have ceased. A central question for community action projects with the explicit goal of seeing the population as the subject is this: In what sense and in what manner is this reorientation to be accomplished? To a certain extent this question is connected to how communication within the project works.

Unidirectional Versus Reciprocal Communication

Community action projects change shape during their ongoing process. However, one can work from a more or less fixed plan or from a looser frame, determined by the interaction between the executive project group and the participants—in our case, the local population and its organizations. Hence, an overwhelming strategic question is this: How can one create a structure of communication within the project that guarantees a reciprocal exchange of information? The type of communication structure established probably will have a great impact on the effectiveness of the project.

Community action programs, not least in the field of alcohol prevention efforts, might contribute in a special way to a new knowledge on how to generally deepen democracy in local communities. In tailoring the organization of the Kirseberg Project, we were faced with the fundamental question: How is it possible to create a model that makes possible the active participation, with democratic legitimacy, of different groups and individuals of the local population? The question is closely connected to recurrent issues in the structuring of various national and local representative democratic systems.

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Problems of Action Research: Some Practical Experiences

Marja Holmila

Introduction

An action research approach was used in two successive way-of-life projects that were arranged with the Central Organization of the Finnish Trade Unions (see later in this volume). Two study reports have been written about the project: one about the first stage (Holmila 1985, 1986); the other about the second stage (Hietanen 1988). The research setting during the first and the second stage of the project differed somewhat. During the second stage the researcher, as well as the whole project, was more inside the organization. The report on the first stage looks at the characteristics of the working sites and the dynamics of the trade union organization and attempts to locate the issues of way of life in these concrete environments outside the actual educational process. In this paper, I will discuss the possibilities and difficulties of action research in light of experiences gained during the process.

Principles of Action Research

The fundamental principle of action research is that the people the research is centered on are included in doing the research. They must be the subjects, not the objects of the study (Mozer 1978; Swantz 1981). Action research attempts to do away with the fundamental dichotomy of social science—the fact that social science is action that studies action. In an ideal case these two aspects would be one. Action research, or participatory research, is a broad concept that encompasses various theoretical frameworks. A very large methodological spectrum can be used within it. It is a research approach, not a methodology. When applied to evaluation, the focus is on understanding what the process meant, rather than measuring the degree of change initiated.

The criteria of action research can be said to be the following:

- People are the subjects, not the objects of the research.
- The researcher takes part in the action of the group by promoting the goals on which they have agreed together.
- The researcher gives continuous feedback on the research—the interpretations are formed through dialogue in which all participants take part.
- Cooperation is based on open interaction.

- Values are recognized as a part of the process.

The theoretical roots of action research lie mainly in the critique of objectivism. Its most distant counterpart is perhaps empirical survey research. Dialectical and understanding approaches, on the other hand, have much in common with action research. Research always affects its object, and in action research one attempts to make this fact a part of the methodology. A great deal of attention is paid to the relationship between the subject and the object of the study.

In European countries the action research approach has been used in various contexts. A typical task has been the evaluation of institutes or programs. In the 1960s and 1970s such studies were connected to critical and democratically organized social planning or education. Alain Touraine's intervention studies of social movements are famous later examples of research inspired by action ideology. In developing countries many European anthropologists taking part in development projects have applied the action research approach there (Holmila 1984; Mozer 1978; Swantz 1981).

Generating Dialogue

Some of the most visible problems of action research are connected to its use of dialogue. On what does generating dialogue depend? Researchers often discuss the challenges for their own skills and attitudes. It has been said that because researchers are well educated and have higher social status, they are always manipulators in the group and will direct the others' actions in light of their own ideas. On the other hand, it has also been claimed that if researchers aim at being only part of the group, they are of no use to the group. Group members expect help on the tasks that the researcher has been educated to do, that is, clarifying the processes taking place and mediating information.

To what extent did the idea of having people be research subjects instead of objects succeed in the Finnish trade union project? How does one know if action research is a realistic goal in the given circumstances? (Answering that question presupposes an understanding of the objective surroundings.) Is process evaluation adequate if it concentrates only on the action and the people's discussion and leaves the analysis of the wider setting untouched?

At least in Finland, many action researchers have felt that institutional conditions—funding and control—have strongly affected the character of the researchers' participation, their relationship with other participants, and the opportunities to collect data. Action researchers often lack the status and liberties of researchers involved in "proper" scientific work (Holmila 1984).

Given the iron strength and conservatism of the trade union organization, the researchers perhaps should have stayed at a distance rather than being active promoters. Both studies on the trade union project seem to have started from an orthodox action research ideology. They came, however, to different conclusions when faced with the difficulties of making these ideals reality.

In the first report (Holmila 1985), the researcher's solution was to turn to the critical, academically flavored analysis of structural factors. The collective ideal of the action was maintained, but the research moved toward an outsider approach, pointing out the possible reasons for the project's difficulties. In the second report (Hietanen 1988), however, the solution was to stay faithful to the original research setting but change the content of the action. The project moved more toward individual questions, and toward typical leisure-time education with very few links to the collective setting of the education. The organization took steps toward the forms of traditional, individual-based education. Discussion content was also affected.

It seems, thus, that at least in cooperation with big, powerful organizations, action research is easily forced to modify its approach. An advantage of action research when compared with ordinary qualitative data collection is certainly access to data that would otherwise be hard to obtain. But what are the disadvantages compared with more formal data collection? The greatest disadvantage is that the researcher risks losing his or her specific task and outlook and becomes one of the actors. Action researchers are forced to address these kinds of advantages and disadvantages.

Validity of the Results

Another important problem in action research is the question of *validity* in the participatory data collection. A common supposition among action researchers seems to be that social science does not aim to discover absolute truth, but rather it strives to understand, clarify, and modify social discourse and social practice. What guidelines then should be used to determine whether a study meets the criteria for scientific work? This question is difficult in all research that uses qualitative data, but it is of particular concern to participatory studies where researchers can be accused of creating the reality they describe.

One criterion that might be used for determining validity is practice. One can say that the validity of an analysis will be proved or disproved by testing it in practice, in further action. On a practical level this testing is a solution but it doesn't help to validate scientific interpretations. Action neither verifies nor falsifies the original interpretation. There is no verification because the action modifies the original interpretation. Action generates an experience that did not exist before and enables the question that the interpretation answered to be formulated more precisely. Modifying the original interpretation is no falsification either—modifications can only be effected through action that in turn is justified by the original interpretation. No theoretical transition exists from one interpretation to another; the transition is exclusively practical (Töttö 1982).

Another point of view is that it is both impossible and undesirable to erase the way a researcher's personality affects the study's data collection and how the data are summarized, combined, and interpreted. Each single study is just one aspect of the truth. Perspective anthropology, for instance, holds that a study is nonobjective only if it falsely claims that its particular partial truth represents the entirety. This view can be criticized for allowing the researcher too many liberties. After all, usually only one report is published.

A third general answer to the problem of validity is intersubjective consensus. If other people making the same observations would draw the same conclusions as the researcher, these conclusions could be considered valid. In order to use this guideline, one should decide who the people are with whom the researcher should reach a consensus. Everyone in the group with whom one is working? What about the scientific community? How should researchers communicate the steps taken in the analysis? Despite these problems the intersubjective consensus is probably the best solution to the problem of validity. Usually researchers present their thoughts during the action process several times to other members of the group and receive feedback. The final report is also usually discussed with the group before publication.

Both researchers in the Finnish trade union project attempted to gain direct comments from the project participants by presenting their results to them. Because very few comments were received, however, and most of them from the upper echelons of the trade union, the two researchers solved the problem of validity by comparing their results with academic discourse traditions. During the project's first stage the researcher had her frame of reference in the studies of work environments and the feminist literature, with which she attempted to achieve some consensus. At the second stage, the researcher was more interested in studies on individual lifestyles and also on adult education. The division of work between the researcher and the teachers' team was also clearer at the second stage, and the interpretations could be discussed between the researcher and the team.

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CHAPTER 3

Brief Case Studies

Experiences from the Field

Louis Gliksman

The brief case studies presented in this section reflect the experiences of those involved in action research projects. Rather than focusing on the methodologies and results of these efforts, as is the usual manner of reporting, the authors were encouraged to maintain the integrity of the symposium and highlight the problems faced and the lessons that they would like to pass on to others. These papers are not identical to the presentations made at the symposium but reflect the subjects initially covered in a more problem-oriented fashion.

The richness of the material in this section arises from the variety of issues covered in the papers and from the authors' willingness to truly share their experiences. The papers are organized somewhat differently from the way they were grouped and presented during the symposium (see appendix B). The papers are presented here on the basis of the prevention strategies the program or intervention uses within the community, whether the target is an entire community or only a subset of a community, such as school children. Although the papers have been grouped on the basis of what I viewed as the primary strategy, it is apparent that there is overlap between the strategies, and many of the papers could logically be placed within a different category.

The papers are grouped into five categories. The first group of three papers reflects an approach to alcohol problem prevention based on environmental regulation of the conditions of drinking and associated damage or problems. Friedner Wittman discusses the differences between two California projects that focus on environmental approaches, one based in the Castro Valley and the other in San Francisco. Ron Douglas looks at the problems of getting a Canadian municipality to change the use of alcohol in its recreational facilities. Robert Reynolds discusses competing interests and political constraints in changing the alcohol environment in San Diego County, California.

From the broad environmental approach, we turn to a series of papers that addresses the regulation of alcohol through sale and marketing restrictions. Here I offer two sets of reflections. The first describes implementing and evaluating a polity-oriented program in a Canadian university. The second paper focuses on the problems of evaluating a server intervention program in a community in Ontario. Robert Saltz and Cathie Delewski outline their experiences in implementing a server intervention program in two California communities.

The third group of case studies share a somewhat different approach to the prevention of alcohol and other drug problems. Seven papers describe various instances in which researchers have engaged in community action by forming groups or alliances for social or political action. From Sweden, Stig Larsson and Bertil Hanson discuss the ethical and political concerns of involving relevant community groups in an alcohol problem prevention project in Kirseberg. Robert Simpson and Paula Stanghetta, working in Ontario, consider the hidden or competing agendas of other community groups. Martin Shain highlights some of the challenges of translating the theory of community action research into action in the workplace. Marja Holmila looks at the problems of working with unions in a lifestyle intervention for workers drawing on a project undertaken with the Finnish Trade Union. Regina Caverson discusses the commitment necessary to implement and evaluate a drinking and driving countermeasure program in a Canadian community. Ernie Lang and Marian Kickett provide a very different field experience with their discussion of the role of community involvement in a petrol sniffing intervention among aboriginal youth in Australia. Finally, Ignacy Wald and his colleagues discuss using the community to provide the plan of action for an intervention in Poland.

The fourth group of papers consider education and persuasion activities about drinking or its consequences as a strategy for prevention. Mary Ann Pentz and her coauthors describe a large project undertaken in two U.S. cities and the differences in starting, maintaining, and evaluating an education intervention in schools. In contrast, Alexander Glazov and his colleagues discuss the general problems of working within the school system in the Soviet Union. Shoshana Weiss outlines the experience of an education program within the kibbutz system in Israel and the special challenges of working within that system. Davinder Mohan and H.K. Sharma discuss the problems of the competing needs of researchers, funders, and programmers in running an education program in two areas of New Delhi, India.

Finally, one paper addresses the role of treatment as a means of prevention—tertiary prevention. Jonathan Chick discusses the issues of community planning of alcohol treatment services in Edinburgh, Scotland.

If I am asked to identify the common lesson to be learned from all these case studies, I suggest that it is to recognize that often the interaction of researchers and programmers with community members, community agencies, or each other determines the success or failure of a particular project.

Experiences from the Castro Valley and San Francisco Projects: An Environmental Design Perspective

Friedner D. Wittman

Societal problems with alcohol are a matter of complex interactions between drinkers and the circumstances in which they drink (Cahalan 1970; Cahalan and Room 1974; Clark and Midanik 1982). This paper is concerned with the impact on alcohol consumption of such factors as the immediate drinking environment (Single and Storm 1985) and alcohol availability at the community level (Bruun et al. 1975).

Social ecologists argue that individual change and environmental manipulation must work together for a prevention initiative to be effective (Smith and Hanham 1982; Wittman 1983a). Preventive education may lead individuals to change drinking behavior if the surrounding alcohol environment is reconfigured to support the change, and if occupants of the environment understand clearly how they are expected to change (e.g., Wittman and Christy 1987). The latter point is especially significant in the United States, where high value is put on the prerogative to use one's environment as one chooses.

Planners thus might do well to focus prevention efforts on changing the environment but doing so in a way that enlists the occupants to voluntarily design ways in which environmental changes will take place.

How might planners proceed? First, planning based on participatory, environmental design has been shown to be a complex iterative activity (Schon 1983; Wittman 1983b). This activity involves many cut-and-try and pattern-matching activities (Alexander et al. 1977) to explore and adopt new configurations that combine changed behaviors with modified contexts (settings). Second, environmental planning for alcohol availability may be most effective when a problem-solving approach toward reducing or eliminating locally perceived alcohol-related problems is taken (Room 1980).

A general form of such planning has three phases (see chapter IV in Wittman and Shane 1988, for an extended discussion):

- Assessment and validation by the local citizenry (agencies, organization) that a problem exists with the community environment.
- Commitment to courses of action to change the local environment.
- Institutionalization (local ownership) of sustained effort to maintain the gains that have been achieved.

Practical Experiences in Community Planning

Two projects are presented as being of particular interest to the praxis of community planning outlined above. The San Francisco project, begun in 1982, partially accomplished the assessment and commitment phases before its end in 1986. The Castro Valley project, begun in 1986, is now in the second year of its institutionalization phase.

The San Francisco Prevention Project (SFPP)

Premise. Alcohol problems (as contrasted to alcoholism) are fundamentally community-level rather than individual-level phenomena. As such, these problems create serious difficulties for the public agencies and community organizations operating in a given community. Community-level problems can, however, be approached as shared difficulties, susceptible to joint action by several agencies. If agencies and organizations are provided the opportunity to explore problems in common and to devise joint solutions, commitments to action can follow aimed at reducing or preventing future problems.

The SFPP sought to provide the opportunity for key persons in San Francisco's leading agencies and organizations to learn about alcohol problems from the community perspective and to move forward to adopt environmental approaches to deal with the problems.

Early period (1982–1983). The SFPP began as a joint project of the Alcohol Research Group, the Medical Research Group of San Francisco, and the San Francisco Community Substance Abuse Service (the county's alcohol and drug program). Following a 6-month recruitment period, approximately 30 community leaders attended five 3-hour Prevention Planning Workshop training sessions that introduced them to a community perspective on alcohol problems and environmental approaches for dealing with them. The leadership represented a high-powered cross section of people from civic government, law enforcement, the public defender's office, city planning, business associations, schools, religious groups, residential associations, voluntary organizations, and health and social services agencies (see Wallack 1984–85) for a full description of the workshop process).

The workshop participants readily accepted the prevention concepts and their planning implications. The remarkably capable participants at one point transformed themselves into a planning group that acted to identify and then to eliminate an incipient threat to public health in San Francisco's alcohol environment posed by pending legislation to permit sale of alcoholic beverages in gasoline stations.

Following the workshops, several disappointing attempts were made to establish specific prevention programs that would modify problematic settings and practices in managing the use of alcohol. The SFPP project coordinator and project director pursued, without immediate results, prevention targets identified during the final workshop session (e.g., an alcohol and family violence project at a child abuse agency; action against street drinking in a minority, low-income neighborhood; consultation to prevent problems in San Francisco's transit system; development of a regulator's guide to describe how to use local ordinances to deal with alcohol outlets).

Later period (June 1983–June 1986). The pattern of the first year was repeated in the second and third years, notwithstanding the SFPP's move to another institution and a shift in the project coordinator from a public health educator to a person with experience in managing human service programs. Again successful workshops were followed by frustration in trying to develop specific prevention initiatives aimed at significant changes in the community's alcohol problem environment.

Despite several initiatives undertaken in the second and third years, later participants and other interested community groups and individuals (in contrast to the first workshop participants) were not mobilized by SFPP staff to carry out the prevention initiatives. Additionally, the several activities that were undertaken were not directly related to each other and did not bring together coalitions of supporters. Instead of mobilizing, delegating, and coordinating, the project coordinator took all the work of the SFPP on herself.

Despite the project coordinator's extraordinary personal efforts and perseverance, the SFPP failed to thrive. After the 1985–1986 year, the county discontinued support for SFPP because the project seemed stalled and repetitious, and it had been abandoned by its host agency. Even so several earlier SFPP efforts and ideas resurfaced in later interventions that were successfully undertaken after the SFPP ended.

Castro Valley Prevention Planning Project (CVPPP)

Premise. The Chair of the Drug Task Force of the School Board for the Castro Valley High School, the most prominent institution in that 45,000-person bedroom community, sought more effective strategies than the classroom-based prevention education activities then offered to deal with young people's access to alcoholic beverages in the community. Considerable groundwork had already been done to raise concerns about young people's use of alcohol. Accordingly, the project planners hoped to build on the SFPP experience and develop specific initiatives to modify problematic alcohol environments.

CVPPP provided an opportunity to infuse new prevention concepts and technical support to augment local planning already underway. A four-part process model was proposed, consisting of validation, commitment, assessment, and planning for initiatives (Shane and Cherry 1987). Validation and commitment would involve the community's own recognition of its problems with alcohol (a process already under way before the planners arrived). Assessment work by the planners would formally describe the problems. Then planners would feed the description back to the community at a forum intended to strengthen the validation and commitment activity and lead directly to planning initiatives to create specific projects for dealing with alcohol problems.

Beginning period (Summer 1986–Fall 1987). CVPPP assessment activities involved a three-part program of documenting local agency and community organization response to alcohol problems; gathering such data on alcohol problems as existed in the community; and working to develop community support for the CVPPP initiative by explaining the project's ideas to various community groups. This activity proceeded smoothly through over 50 interviews and resulted in a report that was circulated at the community forum (Shane and Cherry 1986).

In November 1986 a community forum entitled, "Youth and Alcohol: It's a Community Concern," was held in the Castro Valley High School library. Approximately 150 people attended to review findings of the assessment phase and to learn how local agencies and groups can become more active in planning prevention initiatives in the community.

The participants' transition from talk to action was not left to chance. To encourage activity CVPPP and Drug Task Force analysis of the assessment research identified five areas of concern as likely foci toward which Castro Valley's citizenry might want to direct their intervention efforts: alcohol in families; alcohol in schools; retail availability; support for existing laws; and community (adult versus youth) norms on alcohol. Following the coordinator's presentation, the audience was divided randomly into five groups to address the five areas of concern. Each group was urged to identify possible courses of action and to select a next meeting date within 1 month. The communications consultant and project coordinator worked with each group to ensure that the group successfully completed the assignment.

Later period (December 1986–present). The five activity work groups created at the forum evolved into three distinct planning groups that established, over the next 11 months, 15 distinct intervention activities directed toward the community's alcohol environments (Shane undated). Activities emphasized sober socializing for young people.

A climate of support had been built for prevention programming in Castro Valley that seemed to have momentum of its own. The activity groups were not tightly organized for leadership, membership, and meeting format, nor was a steering group organized. Yet meetings were held, and planning occurred for community activities. This result may have been due in no small part to the activities of the communications consultant, who provided extensive public information and technical assistance to each of the groups in the project.

Institutionalization within the community. In 1988 the CVPPP found a home in Castro Valley. A project "Prevention Newsline" telephone line was set up to help the community deal with alcohol issues. Similarly, a Prevention Post Office Box was established to give the project an address in the community. Impressed by these developments, the county alcohol program committed resources to establishing a permanent prevention program coordinator position in Castro Valley. The incumbent in that position is charged with sustaining activity at similar levels to that established the first year.

Discussion

Comparing the San Francisco and Castro Valley Projects

The San Francisco project did not move to self-sustaining activities to modify problematic alcohol environments but the Castro Valley project did. What were the factors that led to these different outcomes?

Support from key leaders in the community. The unwavering presence of the Chair of the Drug Task Force provided strong support for the CVPPP in the context of a continuing committee that lent both advice and support. The San Francisco project's efforts to develop similar support were only partially successful. Workshop attendance was good, but it was not sustained in the form of continuing support, perhaps because too little attention went to maintaining the interest and support of key leadership in the community once those individuals had been successfully recruited. San Francisco's leadership was sectoral and fragmented, which is perhaps typical in large metropolitan areas. Coordination and maintenance of effort were, therefore, understandably more difficult for the SFPP, and virtually impossible in light of the project's minuscule and isolated staff. In retrospect the SFPP would have done better to concentrate its efforts on a more manageable level (e.g., work with particular areas or groups), and to have expended more effort toward building a constituency and to constructing supportive links with other service organizations.

Work across several agencies and groups. The CVPPP quickly moved from its base of Drug Task Force support to work closely with the three activity groups and related community organizations concerned with alcohol and other drug problems. The SFPP never established significant continuing contacts outside its sponsoring agency. Establishing problem-oriented prevention agendas with community groups and local agencies proved difficult. Both the SFPP and the CVPPP struggled to lift narrow community concerns above individual alcoholism and concerns about young people's drinking. The CVPPP developed its communitywide program by taking concerns about youthful drinking as a starting point and expanding from there to address availability-related issues generally by investigating young people's sources of supply.

Media component. The CVPPP had a staff person dedicated to and trained in communication; the SFPP did not. CVPPP's strong media element communicated project ideas, education, and orientations toward alcohol issues to build broad support among the entire Castro Valley population. The San Francisco project's efforts were far from negligible, but by comparison were unfocused, uncoordinated, and went virtually unnoticed in a city of 700,000.

Multiple program activities. The development of simultaneous projects across the three Castro Valley activity work groups and related organizations provided a network of mutual aid and a gestalt of community activity on prevention. In the San Francisco project, the project coordinator had no support staff and no infrastructure of activity group workers. Thus the day-to-day work fell to the project coordinator directly and proved overwhelming.

Program backup and additional support provided as needed. The Castro Valley Prevention Planning Project was able to call on reserve support from the communications consultant, project coordinator, project consultant, county staff, a statistician, and the chair of the Drug Task Force. As a result intentions could be carried through to action, and things got done. The SFPP had no depth of support for its operations. Total SFPP staff support never exceeded 1.6 full-time equivalent positions. Additionally project activities of the SFPP were scattered in different areas of the city, were uncoordinated, and were unable to provide mutual support. In retrospect the SFPP's extremely limited resources might have been better used to concentrate several activities in one area of the city, rather than to spread these activities so thinly.

Differences in project startup. From the beginning the Castro Valley project intended to move directly into the commitment phase of action on specific problems. The San Francisco project, in contrast, sought first to enlist the support of San Francisco's institutional leadership to take a different view of alcohol problems, and then to convert this changed perspective into task groups that would tackle specific problems. The San Francisco project thus put more effort into investigating the acceptability of an environmental perspective as a way of thinking about community-level alcohol problems and less on action to make environmental modifications dedicated to reducing the problems.

The Castro Valley Prevention Planning Project is a testimony to the groundbreaking San Francisco Prevention Project and to the evolution of community-level prevention planning in California generally. As the concepts become more widely accepted, interest increases and implementation strategies improve.

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Formulating Alcohol Policies for Community Recreation Facilities: Tactics and Problems

Ronald R. Douglas

Introduction: The Program

In 1980, a policy regulating the licensing of alcohol in municipally owned parks and recreation facilities was adopted by the City of Thunder Bay, Ontario. The policy was developed by an ad hoc committee of the city council composed of city staff, representatives from community organizations, and citizens at large. The policy designated one recreational facility as suitable for consumption of alcohol (fully licensing the club room at the curling club), others as appropriate for limited use of alcohol tied to obtaining a special occasion permit (community centers, arena floor spaces, park lodges, and golf course clubhouses), and still others (such as parks and smaller green spaces) as not at all appropriate for accommodating alcohol-related events.

To have the policy positively affect behavior, an extensive marketing campaign, informing the community of the new rules and their consequences and benefits, was launched. The campaign, launched in 1983 and run for a year, carried the theme "Parks (and/or) Facilities Are for People—Please Play by the Rules." The campaign was composed of a mix of news items, public service announcements, and paid advertisements in press, radio, and television. In addition, pamphlets outlining the policy were distributed to groups and individuals making inquiries, theme buttons were given to participants at orientation sessions, and posters were distributed to the various facilities. In essence a sequenced, interactive campaign was implemented to influence people to voluntarily comply with the policy regulations (see Douglas 1986; Douglas et al. 1986; Murray 1986; Murray and Douglas 1988; Murray et al. 1984; Thomson and Douglas 1983; Thomson et al. 1984, 1985 for a description of the program).

To assess the impact of the campaign, a quasi-experimental evaluation design was employed using pre- and posttest measures, a comparison community, and random selection of participants to complete the questionnaire. The results of the Thunder Bay evaluation (Gliksman 1986; Gliksman et al. in press) indicated that the marketing campaign increased the intentions of residents to comply with the policy. Also the Thunder Bay residents surveyed displayed significant changes in attitude: they were more supportive of legal controls on alcohol, less tolerant of underage drinking, less supportive of alcohol use in recreational facilities, and indicated a greater intention to attend and rent facilities in which alcohol was not served, when contrasted against the comparison community. These results were supported by anecdotal reports from recreation staff who noted a decrease in alcohol-related problems and a corresponding decline in complaints received from the public and police.

This paper will highlight some of the interactions involved in developing, promoting, and evaluating an alcohol management policy for municipal parks and recreation facilities in this Canadian community. The interactions discussed will emphasize tactics and problems not reported elsewhere.

Tactics and Problems

Matching Communities

Thunder Bay, the experimental community, is the core of the amalgamation of two large communities and a few rural towns. Basically Thunder Bay is composed of the former communities of Fort William and Port Arthur. As a major shipping port situated at the head of Lake Superior, it is sometimes referred to as the "Canadian Lakehead." With a population base of 120,000, it is the largest urban center in northwestern Ontario.

Walden, the comparison community, is one of the smaller rural communities that exist within the boundaries of the Regional Municipality of Sudbury. The Sudbury area, often referred to as the "Nickel Capital," is the largest urban center in northeastern Ontario with an estimated population base of 150,000. Walden, while participating in regional government, also maintains its own separate identity and municipal government. Walden contributes 10,000 to the regional population count, and is located 395 kilometers (245 miles) northwest of Toronto.

From this description, these communities do not appear similar. However, they are quite comparable in terms of municipal recreational facilities. While Thunder Bay has more facilities and greater park acreage, both communities are similar in their service delivery in that they provide playgrounds, principal park areas, waterfront areas, arenas, ball parks, and community centers. Furthermore, and probably more important, both communities had recreation directors who were receptive to participating in the study.

The community programmers, both Addiction Research Foundation of Ontario (ARF) consultants and City of Thunder Bay Parks and Recreation staff who were responsible for implementing and managing the program, realized that they had an opportunity to replicate the policy interventions in the comparison community, and were prepared to risk the external validity of the study. After all, they thought that if the recreation director in Walden was already receptive, increased involvement should further increase his interest in the intervention. The programmers further reasoned that the measurement in Walden would provide excellent baseline measures for evaluating any future policy intervention in that community.

Unfortunately the gamble failed. The recreation director in the comparison community became disinterested and resistant to all program approaches following the study's completion. One explanation for this change may have been in the way the results were reported. By reporting that Thunder Bay had more supportive attitudes than Walden, the project team may have increased the threat of political vulnerability among decisionmakers and recreation staff in Walden.

The gamble to strengthen potential programming options at the expense of the study's evaluation design risked negatively impacting the relationship between the programmers and the evaluator—for the programmers had steered the principal investigator to this option. Fortunately the evaluator was tolerant to field realities.

Programmer-Evaluator Relationship

The intents of programmers and evaluators, which are guided by a common purpose, may at times be weighted differently. Therefore one of the challenges facing the project manager (a programmer) was gaining and maintaining the interest of an evaluator.

While the assembled project team of programmers and researchers had developed a positive collaborative relationship resulting from other endeavors, it was still necessary to persuade the scientist to become involved in evaluating the program. Within the Addiction Research Foundation's (ARF) Community Services Division there are many programmers, but relatively few researchers at our Community Programs Evaluation Center. As a result, considerable competition goes on among programmers for the attention of these scientists and accompanying resources.

Persuasion consisted of presenting the evaluator with an innovative, challenging idea that had publication possibilities. Publication was stressed because it is not only an interest of ARF researchers but, in many cases, a job requirement. A draft proposal, written in language that communicated a working literacy in research methodology, was enthusiastically presented to the evaluator. Not only did this action set up a dialogue but indicated to the evaluator that his time would not be taken up implementing the program or supervising the data collection.

In exchange for an evaluation design, data analysis and interpretation, associate authorship on publications, and the recognition resulting from the evaluator, the programmers offered an innovative idea, incorporated constructive criticism, managed the intervention, collected the data, and assisted in the writing up of the results. In essence, in terms of social marketers, a beneficial exchange had occurred.

This exchange could be attributed to the initiative of a former director of ARF's Community Programs Evaluation Center. For a few months he established a dialogue between his research staff and key programmers within the

Community Services Division. Through this exchange the research staff schooled the program staff in evaluation methodology.

Publication Dilemma

Publication of the results faced two potential dilemmas: Who would participate as authors and in which discipline would the article appear? Traditionally, only the research staff in ARF publish. Program staff, as a rule, received little recognition in the literature for their efforts. This arrangement appeared inequitable because there would be nothing to write about without the implementation of an intervention. Therefore, in this instance, it was negotiated at the outset that the principal program staff would participate with the researcher as coauthors.

Another sensitive area negotiated was choosing the discipline in which to report the findings—an addictions or recreation journal. Because five previous articles describing the intervention had been published in recreation journals, the evaluation results would be submitted for publication in an addictions journal. The previous articles were published in recreation journals to promote the intervention, credit the work done by the Thunder Bay recreation staff, and to respond to inquiries from the recreation field itself. So when the evaluation was completed, it was decided that the equation should be balanced with the results being reported to addiction workers through their journals and crediting the contribution of the Addiction Research Foundation.

Integrating Server Training

While this program with its emphasis on policy development pertaining to the availability of alcohol was being piloted, my colleagues developed a server intervention program (SIP) that emphasized training and policy initiatives to support that training. SIP was a welcome addition from the project team's perspective because it could be easily integrated into the municipal policy. Once a municipality decided which of its recreational facilities would allow alcohol, then the policy could require that all alcohol-related event sponsors and servers receive SIP training, which, in fact, has occurred. Unfortunately, this process has not moved smoothly and, at times, the SIP intervention and municipal policy program appeared to be competing with each other for organizational support.

The fees charged by ARF to provide server training (a fee established for private sector establishments such as bars, taverns, hotels, and such) were viewed by municipalities, volunteers, and service groups as excessive. They would not implement the server training component without a fee reduction. ARF has responded positively by offering a reduced fee, but only on a case-by-case request basis, thus making it very difficult to replicate the policy in other communities or introduce server training to communities with existing policies—such as Thunder Bay.

A standardized public sector fee would benefit ARF in three important ways. First, the community policy process would be strengthened because reducing alcohol-related problems requires training in addition to policy, procedures, recruitment, and supervision. Second, funds would be generated through the greater number of community volunteers who would participate, and who, being informed about the responsibilities and liabilities of servers and establishments, would increase awareness of the threat of litigation among the private sector, thus generating requests from them for training. Third, because of the number of volunteers who could end up participating in server training because of the municipal policy requirement, the program could be viewed as a major community education program that could positively impact home serving practices as well. For example, in Elliot Lake, the policy requires that 50 percent of all servers, monitors, and event supervisors at an alcohol-related event receive ARF server training. By offering the reduced fee, over 300 residents of this community of 16,000 attended the first series of training events. The SIP trainer is now receiving inquiries from bars and taverns in town about the possibility of training their serving staff and from other volunteers interested in being trained.

Conclusion: Program Interaction

Agents of change, until recently, have tended to promote regulatory interventions at the state, national, or international levels. Such policy initiatives have received mixed responses from legislators (Giesbrecht 1984).

According to Draper (1983), the amount of change possible through the policy solution is increased if citizens are included in designing and implementing these regulatory initiatives. He suggests that policy development requires an informed citizenry supported for its involvement. In Thunder Bay both these conditions were present. ARF data on community and area drinking problems were channeled to the community through the National Dialogue on Drinking Program. The community was aware that it had more people who consumed alcohol and a greater-than-average number of people experiencing alcohol-related problems. Once a problem was identified in recreational facilities, the municipal government invited citizens to participate in the solution.

The potential of such a local policy initiative, even one that focuses only on a segment of the distribution system, is that it can ultimately influence Provincial and national policy. Many politicians with career aspirations to move into Provincial or Federal politics use the election to community school boards and civic governments as stepping stones. Fostering interest and experience in alcohol policy experience locally may result in such individuals' being more informed and receptive to Provincial regulation recommendations should they enter the Provincial or Federal arenas later.

Comprehensive policy development requires local policy development. The policy development process is interactive in that it provides an opportunity for initiatives at the local level to influence decisions at the Provincial and Federal levels. Therefore, Provincial and national policy goals should be supported by increasing our policy initiatives at the community level.

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Prevention Policy and the Perils of Public Administration

Robert I. Reynolds[1]

Introduction

The San Diego County Department of Health Services, Division of Alcohol Services has, over the past 10 years, articulated and advocated a public health approach to alcohol problems and received, on numerous occasions, the endorsement of the political body with jurisdiction over local health and welfare matters (the county board of supervisors) for applying public health principles to reduce community alcohol problems. This endorsement is formalized annually through a legislatively mandated process to approve the county Alcohol Plan. Each year the Division of Alcohol Services further explains new prevention theories as they emerge in the research literature, and the board of supervisors, usually with little comment or discussion, approves the conceptual framework delineated as a guide for developing prevention strategies, activities, and funding.

To the outside observer, the county environment may appear to be ideal for prevention advocates. While other counties in California were struggling to shift the focus away from blaming the alcoholic for community alcohol problems, San Diego County became the first governmental jurisdiction in the United States to formally adopt a legislative policy endorsing increased alcoholic beverages taxes as a public health measure (San Diego County Department of Health Services 1987). These were indeed heady days for alcohol-problem prevention at the local level.

However, just as theory began to be applied practically, alcohol-problem prevention initiatives ironically fell victim to the War on Drugs at the local, as well as the national, level. The status of alcohol problems was reduced to that of a gateway drug for youth who developed problems with "real" drugs. Local initiatives to influence the climate surrounding societal norms of alcohol use lost their potency in the rhetoric of war.

However, the story of the rise and fall of the public health approach to alcohol-problem prevention in San Diego County is not over and will not be in the foreseeable future. It is a work in progress.

San Diego County and Alcohol Problems

The county of San Diego is 1 of the original 27 counties created by the California State Legislature in 1850. Like much of California, San Diego County has grown at a rapid pace over the past 18 years. Between 1970 and 1987 the population of San Diego increased by 64 percent. It is now the second most populous county in California and the fifth most populous in the United States. The city of San Diego represents almost one-half the county population and ranks as the seventh most populous city in the United States. The rest of the population lives in 17 cities, ranging in size from 5,000 to over 120,000 inhabitants, and in the rural unincorporated areas of the county. Thus, San Diego includes a diverse mixture of urban, suburban, and rural communities that are representative of much of California.

In addition to the geographic diversity, San Diego includes a mixture of racial/ethnic and special population groups. According to 1980 census data, minorities account for 27 percent of the San Diego population, with the largest groups being Hispanics (15 percent), blacks (6 percent), and Pan-Asians (5 percent). While current estimates are unavailable, it is generally believed that minorities now compose a much larger portion of the population of San Diego. In addition, over 120,000 active-duty military personnel reside in San Diego County.

Alcohol use and alcohol problems are found throughout the county. An estimated 1.5 million San Diego adults use alcohol, with an 170,000 estimated to be frequent heavier drinkers. A recent high school survey indicates that by 12th grade 89 percent of students use alcohol; 27 percent use it once a week or more. This consumption results in deaths, injuries, and lost productivity—an economic cost of over $1 billion annually.

Other alcohol problems are apparent in San Diego County as well, including traffic deaths and injuries, police enforcement problems, and an increasing demand for alcohol-recovery services. Public intoxication represents an area in which law enforcement and health services have provided a coordinated response to a specific alcohol problem. During 1987 over 40,000 police actions were related to public intoxication; over two-thirds of these actions resulted in diversion to an alcohol agency.

Similar data are available on other measures of alcohol problems in San Diego County: In 1987 over 42,000 misdemeanor alcohol-related arrests were made, traffic crashes where alcohol was involved resulted in over 200 deaths, and cirrhosis was the listed cause of death for more than 280 residents. Within this complex and diverse broader environment, county Alcohol Services attempts to influence the environment surrounding alcohol use.

The Development and Implementation of Public-Policy-Based Prevention

The shift from the more traditional, individual-education-based prevention activities of county Alcohol Services to a policy-driven, environmentally focused prevention strategy began in the late 1970s. This shift was stimulated by local experiences in responding to public inebriety problems and reinforced by the emerging literature on public-policy approaches to reducing alcohol problems. Articles by Worden (1979), Beauchamp (1980), and Gusfield (1982), outlined the conceptual framework and research evidence for environmentally and policy-based prevention strategies and provided a historical perspective on the experiences of alcohol-control policies in managing alcohol problems.

An analysis of public inebriety issues was prompted by an unexpectedly low use by local law enforcement agencies of a new inebriate reception center designed to relieve jail overcrowding, especially because of recurring court orders to reduce it. The significant finding of this analysis (San Diego County Department of Health Services 1979) was that most public inebriates, heretofore regarded as classic downtown skid row bums, were under 35 and were being picked up in such diverse locations as airports, beaches, and the sports stadium.

These events, combined with increasing concern about the effectiveness of traditional, school-based prevention, prompted Alcohol Services to develop a position paper (San Diego Department of Health Services 1981) on using public policies to reduce alcohol problems. Not surprisingly, the paper generated lively discussion and controversy, especially among alcohol-service providers and the local citizen advisory committee, the Alcohol Advisory Board. The popularly held theory that alcohol problems are the result of alcoholics seemed as immutable as the American faith in the power of education. Inherent in the debate was an underlying tension regarding the appropriate role of the public sector, most notably the careerist public administrator, in advocating prevention agendas.

By adopting a data-based planning model (Ryan and Segars 1988), county Alcohol Services defined its role as that of information broker to assist communities in identifying alcohol problems and adopting strategies to reduce problems. Initially this action required a discernible, if not substantial, investment of resources to support literature reviews, data analyses, community prevention seminars that brought noted prevention scholars to San Diego, and, ultimately, the generation of reports based on data analysis and literature reviews related to local alcohol problems.

These activities were not without controversy. Detractors objected to overemphasis on what was construed as research activities to the detriment of services to suffering individuals. Emerging parent groups demanded greater investment in school-based prevention at earlier and earlier ages, dismissing the mounting evidence that such activities, while popular, do not appear to be effective. The appropriateness of alcohol-specific prevention was increasingly challenged as quixotic in the age of polydrug use.

In one domain, Alcohol Services welcomed the controversy because it placed alcohol-problem prevention on the public agenda. Indeed, the county board of supervisors not only adopted what was considered, in wine-producing California, a radical policy to increase alcoholic beverage excise taxes by equalizing the tax rate on beer and wine to that of distilled spirits, but also routinely ratified annual plans for Alcohol Services that incorporated the newest thinking on public health responses to alcohol problems. The supervisors also approved a series of projects to increase the data-analysis capability of Alcohol Services, to develop a series of environmentally focused training materials on prevention, and to expand community education activities, including seminars and conferences on such topics as "Alcohol Control Policies" and "Implementing Environmental Strategies for the Prevention of Alcohol-Related Problems."

The governing assumption of Alcohol Services was that research-based, data-driven recommendations would prevail in the adoption and implementation of alcohol-problem prevention strategies. The assumption that this event would occur had been reinforced by the ratification of the conceptual view and the planning process by constituency groups and elected officials. As it turned out, the flaws in this assumption were the failure to differentiate between conceptualization and implementation, and the underestimation of the power of the popular press to shape the public agenda regarding the severity of the drug war.

Mid-way through the Reagan administration, the War on Drugs reached a fever pitch with a resultant scramble by politicians to be tougher on drugs than their opponents. Locally, this situation led to challenges as to which political candidate would be the first to take a urine test in lieu of challenges to debate the issues. While alcohol problems were noticeably absent from the drug war rhetoric, county Alcohol Services was nonetheless confronted with the need to explain its lack of enthusiasm for popular drug prevention events such as spelling out "Just Say No to Drugs" on the deck of an aircraft carrier or "Drug-Free San Diego" campaigning. Did the county really wish to endorse an alcohol-free San Diego, alcohol being a drug? Did the county wish to be dry by 1990?

While Alcohol Services' responses were faithful to the integrity of the conceptual framework of the planning model, they were not well stated or disseminated. When community leaders noticed Alcohol Services' lack of participation in such popular efforts, they were often left to their own interpretations of these decisions. In the late 1980s, Alcohol Services did not readily acknowledge and respond to the shift in the public eye from alcohol-impaired drivers and public inebriates to cocaine-addicted babies—from alcohol to illegal drugs. Providers of county-funded alcohol services became confused and angered by the loss of popularity and public support for alcohol issues. Who could be at fault?

These experiences underscored the need for Alcohol Services to better articulate its prevention perspective not only to the policymakers and constituency groups, but also to the general public. The social marketing of research-based policy recommendations was lacking. While advancing the concept of using public policies to moderate the drinking environment as part of an abstruse conceptual framework was relatively easy, it was quite another thing to sanction government intrusion into a legitimate commercial activity like the marketing of alcoholic beverages. For example, included in the prevention materials developed for community groups with public funds is a guide on "Increasing Community Involvement in Alcohol Licensing" (Applied Communication Technology 1987). When Alcohol Services brought forward a grant proposal for external funding to distribute the guides to community planning groups, one of the arguments opposing the request was that such activities smacked of social engineering. In addition, the oft-repeated argument that measures to limit alcohol availability do not work because alcoholics will always find a way to drink resurfaced.

These responses, despite 8 years of endorsement of the public health perspective, provided a rude awakening to county staff. The past actions and agreements on governing principles for the prevention of alcohol problems in San Diego County seemed to have disappeared. Were the carefully designed data reports and literature reviews irrelevant to the realpolitik of implementation? Or was it the failure of Alcohol Services to market those reports and reviews in the broader social environment?

Lessons Learned

The primary flaw in Alcohol Services' strategy for advancing a public health approach to prevention was the misconception that a well-grounded policy presumes a basis of support for future action. Careful attention was paid to laying the foundation for policy decisions to maximize a reasoned and incremental consideration of the issues. However, historical references lose their potency in the here and now of public decisionmaking. The leap from concept to real-world implications must receive regular and repeated consideration in the political arena to assure constancy of the policy. Referencing policies adopted in the past on a purely abstract level as the basis for ratification of an activity is certainly not sufficient, especially when the focus of public attention has moved on to new concerns and when the currency of problems must be reestablished.

Furthermore, Alcohol Services had unrealistic expectations for the county-funded direct service providers—that they would be the principal community advocates in the political arena for implementing environmental change strategies. Individuals working in service programs are essentially advocates for victims of alcoholism in the ongoing campaign to destigmatize alcoholism and educate communities about the disease. Thus, acceptance and acknowledgment of public-policy responses to alcohol problems by alcohol services providers should not presume a willingness to advocate and lobby for those policies. It may be that there are fundamental role conflicts between being good at responding to the individual victims of alcohol problems and being good at altering the environment contributing to the development of those problems. At any rate, Alcohol Services found itself a lone, unpopular voice at a time when a choir was needed.

Future Direction

New action is needed in San Diego County to implement public health approaches to preventing alcohol problems. As a first step, the voices supporting policy-driven prevention must be expanded—a task that requires a concerted effort to develop a prevention constituency. Although that constituency will include direct service providers, it must also include the individuals and organizations who are affected, and thus concerned, with the broad range of community problems. For example, the issue of drinking problems in public parks may engage disparate groups such as park neighbors, parents, and environmentalists. Alcohol Services must design and sustain mechanisms to inform these groups about their legitimate role in shaping policy responses to these problems, as well as provide them with the tools to be effective spokespersons for change.

In the future, Alcohol Services will be more attentive to the role of information dissemination and public education in its interactions with the community and with the board of supervisors and will present policy recommendations in an educational context. Alcohol Services is also funding a series of seminars on prevention policy for local elected officials representing the many governmental jurisdictions in the county. It is to be hoped that these efforts, combined with the natural swing of the public opinion pendulum, will provide expanded understanding of alcohol policy issues in San Diego County in the foreseeable future.

Notes

1. The opinions expressed herein are those of the author and cannot be construed as reflecting the views of the Department of Health Services or the County of San Diego.

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Campus Alcohol Policies and Education Program (CAPE): Practical Considerations in a Research Evaluation

Louis Gliksman

As concerns about alcohol and drug-related problems among college students have increased, so have the number of programs specifically designed for this population. However, most of these programs have had minimal or no evaluation. Those programs with evaluations have tended to be peer counseling programs and have focused on individual student reactions to the intervention rather than on questions of impact. This paper describes the process of evaluating a program developed by the Addiction Research Foundation primarily for first-year students (Campus Alcohol Policies and Education Program (CAPE)). A full description of the program, its rationale, and the results of the evaluation can be found in Gliksman et al. (1987). Briefly, the program incorporated a policy component with the more traditional awareness campaign and thus was aimed at having an impact on the entire university community. Consequently the evaluation was designed to be diverse enough to focus on the primary target but to examine other sectors of the university population as well.

Method: The Plan

The study was designed as a randomized, experimental, field study. The initial plan was to have access to the registrars' lists of incoming first-year students at both the experimental university and at the university chosen to be the comparison site. From these lists random samples of 1,500 students were to be selected who were then to be sent a survey by mail before their arrival at the university (i.e., in August). One week later all subjects were to be sent a reminder letter. One week after the reminder, students at the experimental site were to be sent the educational material under cover of the university. The material was to be sent by the university because we felt that students would be more likely to read the material if it was perceived as being part of the initial university documentation.

Eight months later, these same 1,500 students in each university were to be sent a second survey, which would serve as the posttest and which would be identical to the first except for changes that would accommodate the 7 months they had been on campus. The experimental group would also be asked about their awareness of the program and their reactions to it.

In addition to these questionnaires, other data sources were proposed. To capture the effect of the intervention on the rest of the student population, brief interviews would be conducted with random samples of second-, third-, and fourth-year students. To determine the effects of alcohol on violent acts and student vandalism, arrangements were made to review the records of campus police. Finally, to determine the effects of the campaign on the drinking practices of students, we were to be permitted to review and monitor the sales data of the university bars at both sites.

Problems Encountered and Changes Made

Initial arrangements and agreements notwithstanding, a number of events occurred that necessitated changes in both the implementation of the program and the collection and analysis of the data.

Implementation Problems

Initially, both universities agreed to provide us with complete lists of all students whom they had accepted into first year. We were then to randomly select the 1,500 students from these complete lists. Only the experimental site provided us with a list. The control university decided to select 1,500 students itself and send us their names and addresses. While we asked them to randomly select these students from the entire list, we found out after the study had begun that they had sent us the first 1,500 names on their list, thus making generalizations tenuous.

We had anticipated that during the course of the intervention a number of the policy initiatives that had been accepted in principle by the alcohol advisory committee would be implemented. However, because of the reluctance of the representatives of some of the departments involved in the sale of alcohol who were on the alcohol advisory committee, these policies were never adopted or even formally considered for implementation. In addition, one of the policies that had been implemented (differential pricing) was the cause of a great deal of concern for the managers of the various bars on campus and resulted in a number of confrontations.

Briefly, the policy is based on the premise that students could be encouraged to drink lower alcohol content beverages by providing a monetary incentive, i.e., that beer be priced according to alcohol content, thus making 2.5 percent beer less expensive than 4.0 percent beer, which in turn was less expensive than 5.0 percent beer which was then less expensive than 6.2 percent beer. Each type was to differ in price by $.25. In fact, 6.2 percent was already more expensive, and so only two new pricing strategies needed to be introduced.

Initially some managers resisted the $.25 difference and so accommodations were made for them. Others resisted selling the very light beer and so this requirement was dropped. The final agreement had differential pricing for 6.2 percent, 5.0 percent, and 4.0 percent beers, with one bar having a $.25 differential, a second having a $.15 differential, and a third having only a $.10 differential. After

2 months of operation, managers refused to continue with the differential pricing policy because they claimed they were losing too much money. Although the members of the alcohol policy committee supported the policy, they were reluctant to confront the student managers and agreed to drop the policy completely and reverted to the initial, uniform pricing policy part way through the year.

The ads that appeared in the student newspaper were designed to promote and reinforce the four appropriate behavior messages initially presented in the booklet sent out by the university. The university chose not to have its name associated with the messages in these ads, thus effectively disassociating itself from the theme of the campaign and the booklet initially sent out. This occurrence reduced the consistency of message for which we had strived.

As part of the process evaluation, we had hoped to monitor the implementation of the policy and educational components. While it was relatively easy to monitor the latter aspect of the intervention (that is, did it occur or not?), it was more difficult to monitor the former. We could determine whether the alcohol advisory committee sanctioned a particular policy, but it was generally difficult to ascertain whether the bar managers and serving personnel implemented the policy as required.

We were required to operate on faith, although it became apparent during the evaluation that numerous policies were being routinely ignored. A number of the policies that had been implemented were viewed as unworkable, or were unpopular with managers, and violations of these policies were routinely ignored although the policies were still officially in effect. For example, ensuring that food was readily available on all occasions when alcohol was sold was deemed appropriate but difficult to enforce in certain settings, and limiting the number of special, licensed events was seen as potentially discriminatory. Neither policy was enforced even though both had been sanctioned by the alcohol management committee. One lesson to be learned from this experience is that policy statements should be passed by the university senate to stress administrative support and provide the administration with power to act when policy violations occur.

Data Collection Problems

In addition to these problems with the implementation of the intervention, a number of significant, but unanticipated, problems arose with the data collection procedures.

Because the lists of students from which our samples of 1,500 were drawn were not the final lists of students who attended, but only those who had been accepted and who had indicated a willingness to attend, a significant proportion of students in each school sample (approximately 20 percent) ultimately did not attend the university for which they were drawn. The loss of subjects for the study was further exacerbated because the surveys were sent to their parents' homes and the students had moved or were working out of town for the summer. In either event, the students did not receive the first survey and probably the education package that followed 2 weeks later. Also, the posttest surveys were sent to the initial addresses of those students who actually had registered in the university, and consequently many surveys were returned to us as not deliverable because the student had moved. Finally, because some students chose not to fill out the surveys at all, some did not fill out the same survey twice, and others were unpredictable about when they filled out a survey, the number of students who filled out both the pretest and the posttest was lower than expected.

We had proposed to use the records of the university security department to assess the impact of the program on campus violence and vandalism. We were told that these departments routinely collect information about offenses and document whether charges are alcohol related. By inspecting these records before and after the intervention, we had hoped to determine whether alcohol-related problems had decreased. Unfortunately the records we were provided were unusable. They tended to be incomplete and sporadic in the frequency of their completion. More important, virtually no variability existed in the extent to which offenses were alcohol related; offenses were invariably linked to alcohol use. Thus one anticipated source of data was unavailable.

To determine whether the program had some impact on the drinking practices of students, we had proposed to look at the sales records of the various campus bars at both study sites for the year before the beginning of the campaign and again for the period during which the intervention was in place. We could not do so because the managers of the experimental bars refused to provide their records for the periods requested. The most they were willing to provide was the overall sales data in terms of revenues generated and not in terms of volume and types of beverages sold—the data that we had requested and that we required for the analyses we wished to make.

The analyses conducted at the outset of the program were done exactly as they had been initially specified in the research proposal. They did not anticipate the difficulties and problems encountered. Not surprisingly, therefore, the initial results showed few direct effects of the intervention. However, other data we had collected from the general student population and the experimental subjects suggested that something positive was happening. We found that students were aware of the program and they recognized the themes of the campaign. They agreed with the policies that were put into place and felt that the policies had had some impact on their behaviors.

Somehow the inconsistency between the positive feedback we received and the minimal program benefits we observed had to be resolved. Closer inspection of the data revealed that the initial messages run during the beginning of the study were not remembered, while those run at the end of the campaign, closer to when the posttest surveys were sent out, were remembered. In addition, the policies were dropped in the 2 to 3 months before the posttest, which meant that whatever impact these policies may have had would not have been detected because they were not in place at the time of the evaluation.

Revised Intervention

Based on these data, a second intervention, with a modified evaluation, was planned for the next year to capitalize on the lessons we had learned. Two major changes were made in the intervention itself. First, the bar managers were contacted and asked to provide input into the policies that they were being asked to support. Only those policies for which we could achieve unanimous endorsement were implemented. This strategy ensured that managers would not sabotage policies that they did not like, but also meant that the list of policies implemented was significantly abbreviated from the list initially implemented.

Second, the media campaign was conducted over a much shorter time. The four messages were run during a 2-month period after which the posttest was conducted. The intent then was to determine whether the program had any short-term impact. The results of this second set of data were most encouraging. They suggested that significant positive changes occurred in knowledge about alcohol, attitudes toward the various uses of alcohol, and behaviors with respect to alcohol among first-year students exposed to the program when compared with students who were not exposed to the program.

Interpretation

Despite the positive results of this evaluation in terms of knowledge, attitudes, and behavior, the modifications we had to make in the design and the problems with our samples meant that our results can only be interpreted cautiously. The consistency of these results with those obtained in the interviews conducted with randomly chosen students in the general university community also supports the view that the present program has potential. However, the positive effects, even if they could be unequivocally attributed to the intervention, cannot be assumed to be long-lasting. In fact, some of the initial results suggest that the messages are forgotten relatively quickly, and policies that are ignored or retracted certainly lose their impact. Further research is required to determine how long the program impact lasts and to encourage the adoption of strategies to promote long-term impact.

Although we experienced a number of problems, we felt that the study did answer a number of questions. In particular, the study reinforced the view that the university had a role to play in the use of alcohol by students, and that this role could be positive and effective if specific steps were followed and certain features incorporated.

Although a number of universities in Ontario endorsed the program, most were selective in accepting our recommendations about implementation. For example, we recommended that the educational material, the "Appropriactivity" booklet, be sent to students before they arrive on campus to increase the likelihood that they would read the material. Once students are on campus, the likelihood of their reading this kind of literature decreases dramatically. Unfortunately, universities typically chose to disseminate the booklets during orientation week when the booklet is just one of a number of information packages students receive.

Part of the rationale for this approach by the university administrators is that if parents see this material as coming from the university they may perceive that the university has a serious, unique alcohol problem and may choose not to send their children to that facility. A second factor that was probably more influential in this decision is the cost of mailing out thousands of booklets. Although we recommended that some policies were crucial, most of the universities chose to implement very few of them. Typically implemented were those policies that create the least amount of controversy and, hence, from our perspective, tend to have the least impact.

In addition universities were encouraged to expand the media campaign because increased exposure to the messages should increase the likelihood of change. Feedback from the universities that adopted CAPE indicated that rather than increasing, media exposure seems to have been reduced both in frequency and coverage. No compelling reasons for this were given.

Student opposition to CAPE, supported by concerns from other university-based programs, has been extremely vocal. Although the majority of students appear to endorse the program, others have lobbied against it, maintaining that it undermines the independence of student organizations and tends to treat students in a demeaning fashion, i.e., as not being able to control themselves.

Despite these objections, the Council of Ontario Universities recently launched a policy and education initiative based on CAPE. Whether the program benefits from the lessons we have learned and incorporates the features we have found to be necessary remains to be seen. The encouraging aspects of this intervention are that the program's goals have been endorsed by all Ontario's university presidents and the initiative includes both awareness and policy components. In addition, because the university has taken the primary initiative in implementing the program, continued support for the program is more likely—something that did not occur when the project was viewed as an outside initiative.

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Experiences with Community-Based Server Intervention Programs in California

Robert F. Saltz and Cathie H. Delewski

Research indicates that over half the intoxicated drivers involved in motor vehicle crashes have come from licensed establishments—bars, restaurants, and sporting events—that sell alcoholic beverages (O'Donnell 1985). Efforts to reduce these alcohol-related motor vehicle fatalities and injuries through individually oriented strategies such as education, deterrence, and treatment have had limited impact on the 25,000 traffic deaths that occur each year in the United States. As a complement to these individual intervention efforts, prevention experts have recently begun to examine the environmental factors that contribute to the risk of alcohol-impaired driving. One of the environments receiving close scrutiny is the licensed drinking establishment.

A licensed drinking establishment cannot be expected to implement any changes related to alcohol service unless there is an incentive. These incentives can be related internally to the operation of the establishment (e.g., profitability, management's acceptance of a program's goals) or externally through community incentives that would maximize participation. The community environment is viewed as one of the most critical arenas in implementing any type of program in the hospitality industry. The purpose of this paper is to address the process of implementing a community-based server intervention program.

Server intervention refers to a broad set of strategies to create safer drinking environments by altering the behavior of servers and the way in which alcohol is served and promoted. The central assumption of server intervention is that individual-level prevention programs alone cannot overcome the counteracting environmental factors that contribute to alcohol problems. The goals of a server intervention program are to reduce the risk of intoxication and reduce the risk of intoxicated persons harming themselves or others (Saltz 1987).

Server intervention involves developing a coherent set of policies and procedures within the establishment and then training employees to meet the standards necessary to carry out those policies. Policies are not limited to a prohibition of alcohol sales to minors and obviously intoxicated persons, but also include the availability and promotion of nonalcoholic beverages and food, standards for customer behavior, maintenance of minimum staffing levels, providing alternative transportation for intoxicated customers, and full management support for servers who limit their customers' consumption.

The Project

The Monterey-Santa Cruz Community Responsible Beverage Service Project, operating in Northern California, was developed by the collective efforts of the Trauma Foundation (San Francisco, California), the Prevention Research Center (Berkeley, California), and the Responsible Hospitality Institute (Springfield, Massachusetts). The goal of the project was to develop and evaluate a community-based server intervention program.

The Monterey-Santa Cruz County areas were chosen in part because of the involvement of two local agencies interested in implementing a server training program as part of their funding grants from the Henry J. Kaiser Foundation and the California Office of Traffic Safety. Preliminary contacts by project staff with the hospitality industry in the two-county area indicated an interest in beginning a server training program. Project staff determined that the environment created an ideal situation for implementing a comprehensive community-based responsible beverage service program. Fortunately the two counties are relatively similar, with high tourist and agricultural industries, multiethnic composition, and adjacent geographic areas that are somewhat isolated from other California areas. The 2-county area covers about 3,800 square miles (Santa Cruz being the smaller county with 440 square miles). The population is approximately 550,000 according to the 1986 U.S. Census estimate. The local tourist bureaus have estimated that an additional 7 million tourists visit the area each year.

The following three objectives were developed to achieve institutionalizing Responsible Beverage Service (RBS) training:

- First, the project would create community interest and support for RBS as a legitimate responsibility of the hospitality industry.
- Second, community-based training for managers and servers would be offered at no or low cost to the participants.
- Third, the project would select and train a team of RBS trainers and facilitate long-term support for their continued activity.

Each of these objectives had, in turn, an associated strategy. To create community interest, project staff developed contacts with the more visible members of the hospitality industry, county health officials, community health promotion organizations, and law enforcement officials. The plan was to assemble a task force in each county and then arrange for a community awareness event. As described below, the plan evolved differently in the two counties.

In addition to the strategies associated with each objective, there was as well a nonspecific strategy that may best be described as opportunism, whereby project staff were ready to respond to requests (or demands) by members of the hospitality industry or by public officials in circumstances where the project could mediate between divergent interests.

The project is only now working on establishing a long-term RBS training capability in Santa Cruz County. There, the Santa Cruz Restaurant Association is helping form a Hospitality, Health, and Human Development Commission to oversee training for both the industry and special use permit applicants. It is too early to tell how this effort will turn out.

Experience

As it turned out, the two counties, although similar demographically, were very different politically. This difference was, in our minds, the single most important influence on the course of the program for each county.

Santa Cruz

The Santa Cruz County area has had multiple political controversies over the past 3 years and continues to struggle with issues related to alcohol service. Controversies included banning alcohol sales and consumption of alcohol on city beaches; proposing early closure of bars and restaurants in the city of Capitola (a beachfront tourist town) because of excessive noise and unruly behavior of patrons; proposing mandatory server training for 1-day special events where alcohol is sold; enacting a law enforcement decoy program (in which confederates posing as underage or intoxicated patrons, under police surveillance, seek service); and petitioning of city councils by off-sale businesses to sell alcohol and gasoline concurrently.

Although there was agreement on what the major controversies had been, varying perceptions exist as to how specific groups responded to the controversies. For example, law enforcement officials quickly noted a significant decrease in the number of fights, accidents, and injuries related to the consumption of alcohol on the beaches as soon as the ban was enforced. Several government and law enforcement informants noted that the hospitality industry was not taking enough action to diminish the public safety concerns regarding the service of alcoholic beverages. One local official noted that the hospitality industry frequently requests that government not interfere, yet he had not seen industry members taking adequate responsibility to regulate themselves. The hospitality industry, although supportive of the intended results of some of these issues, was disheartened by the manner in which the law had been enforced. These varying perceptions were not unlike what had been anticipated at the onset of the project.

The controversy surrounding early bar and restaurant closure in Capitola led to a positive outcome. At public hearings before the Capitola City Council, neighborhood residents, restaurant and bar staff, and a member of the project staff testified as to the feasibility of the early closure proposal. Because of the efforts of the project, a settlement was negotiated in which a task force was set up to study the problems and determine solutions. This task force was composed of both residents and hospitality industry members.

Several solutions were proposed, including a proposal that beachfront establishments would agree to receive responsible beverage service training to decrease the number of intoxicated patrons leaving their businesses. Subsequently the ordinance was postponed until the proposed solutions could be implemented and evaluated.

Another unanticipated outcome was a pilot project that grew out of a political controversy regarding alcohol sales permits for 1-day special events. In general, the hospitality industry is adamantly opposed to any type of regulation and therefore lobbies against such regulation. In addition, the hospitality industry and the county public health agency were typically in adversarial roles with regard to the sale and consumption of alcohol. However, the industry and alcohol administrator worked cooperatively to negotiate a plan for 1-day permits that was presented and approved by the county Alcoholism Advisory Board and subsequently the county board of supervisors. This plan was created after a 3-month pilot project in which the project trainers conducted training for event managers, city and county parks and recreation personnel (who are responsible for issuing permits), and volunteer servers.

The results of the pilot study pointed to the need for continued voluntary participation but with built-in economic incentives to increase participation. The cooperative efforts of these two adversarial groups was one of the most positive outcomes of the project, though it was not, of course, a primary goal.

Monterey

When hospitality industry leaders were interviewed in Monterey County, it was clear that they were embedded in the community and had a high degree of community consciousness. The lack of political or social controversies in Monterey, however, appeared to have a deadening effect on their interest in server training. All these leaders noted the benefits of responsible beverage service but took little initiative in recruiting their membership for training. Another impediment observed was that the local organization was composed of more hotels and motels than restaurants and focused only on the coastal tourist areas.

It seems then that when there are political and social controversies, the hospitality industry is forced to respond. The more current the controversies, the more likely the industry will participate in activities that enhance their overall business outlook (both economically and politically). The key element is the ability of the industry organization to act in a proactive rather than a totally reactive way. It was evident in Santa Cruz that the efficient industry organization was more willing and able to deal with the social climate. However, a strong industry may also become part of the controversy through its actions.

If there are few or no controversies, there appears to be less probability of generating active interest and implementing a program successfully. In addition it is important to ascertain the strength and organization of the local industry and determine who the key players will be and what their commitment to the program is. A carrot-and-stick approach might be more of a catalyst than assuming that the industry will generate action on its own.

Unfortunately, efforts to increase industry ownership of the project in Monterey County never really materialized. More coercive strategies were eventually adopted by the project to prompt industry action. For example, to enlist the industry's participation in training, the executive committee was informed that its cooperation would assist in keeping a special Alcohol Beverage Control (ABC) decoy program out of Monterey County. Subsequently, the hotel and restaurant association endorsed the training program, provided a site for training, and the president of the association signed a recruitment letter to encourage participation. In addition it was pointed out that server training might mitigate or at least prepare the hospitality industry for responding to routine enforcement activities. Only at that time did executive members of the organization agree to endorse the project. The project staff implemented the recruitment strategy and planned the dates and times for training.

Working cooperatively with the hospitality industry is important when a strong, community-minded organization exists. Using a coercive tone with a strong industry organization in a politically charged atmosphere can backfire (as did the decoy program in Santa Cruz described later). When the industry is fragmented, however, more coercive approaches may be beneficial to facilitate involvement in the program.

Lessons Learned

As a result of our experiences, we believe a sponsoring agency must assess the sociopolitical climate in a community before organizing any type of responsible beverage service program. One of the errors project staff made was relying on other community agencies for information regarding the feasibility and interest of the industry and community agencies in implementing a communitywide program. If the project staff had conducted the analysis, other strategies and contacts may have been made, which would have alleviated some of the problems and missed opportunities that were encountered.

The analysis should address the following areas:

- The past and present political controversies that focus on the service and selling of alcoholic beverages.

- The key players involved in these issues.
- The characteristics of the hospitality industry in the community, including the strength of the organization, limitations, key leaders, and attitudes about alcohol service.
- The types and number of alcohol treatment providers, relationships to each other, and relationship to the hospitality industry.
- The current governmental proposals or ordinances regarding the sale of alcoholic beverages.
- The perceptions of law enforcement of the hospitality industry and previous interventions.
- The nature and strength of voluntary community organizations (e.g., Mothers Against Drunk Driving, National Council on Alcoholism).

A second major factor affecting the course of the project was its affiliation with other, seemingly like-minded organizations. The project established working relationships with two indigenous programs in the region. One, the Community Health Promotion Program of Monterey County, had been active in heart disease prevention and was interested in alcohol topics, and the other was a driving-under-the-influence (DUI) prevention project, funded by California's Office of Traffic Safety, that primarily emphasized law enforcement and underage drinking drivers. These affiliations did not work out as planned, and while the relationship with the first group faded away, the DUI project's actions actually hindered the project's ability to gain rapport with the hospitality industry in Santa Cruz.

Initially, these two groups were expected to take a leading role in implementing the project. They had presented themselves as very knowledgeable and embedded in the community, with excellent resources for facilitating the project. The result, however, was less encouraging. Both agencies had alienated various other community agencies (especially alcohol-treatment and prevention programs) because they had failed to assess the impact their grants would have on the community, and they had maintained little or no communication with other agencies regarding their plans. Subsequently the first agency exhausted its funding and closed. The other agency, after difficulty with the county's monitoring agency regarding its goals and management of grant funds, was suspended until audits could be completed. The project lost a significant amount of training monies, which caused a realignment in the project budget as well as precluded any further community trainings.

Furthermore a program was initiated by the second organization in Santa Cruz County in which law enforcement and ABC personnel visited each licensee with an educational and inspection program. From their perspective, the primary goal was to educate each establishment about serving laws and crime prevention. If violations were found, no citations were issued although the number of infractions was noted. Both law enforcement officials and the ABC staff were pleased with the results and felt that their efforts had been successful.

However, the hospitality industry viewed the program quite differently. The reaction of many owners and managers was one of fear and paranoia. Few establishment owners or managers felt that the program was education oriented and worried that law enforcement officers were using the program to find as many violations as possible. Although project staff were instrumental in facilitating discussion between the sponsoring agency, law enforcement, and hospitality representatives, miscommunication continued and at one point the hospitality industry indicated that it might not continue to cooperate with the server training program. Only after several face-to-face meetings with the parties involved was the air cleared sufficiently.

As discussed previously, fostering good working relationships with key community groups is important. Another error made by project staff was to minimize the role of law enforcement. Based on the experience with the decoy program, it became evident that allowing one of the cosponsoring agencies to build strong ties with law enforcement, in lieu of the project staff fostering these bonds, slowed down some of the progress being made and potentially could have damaged the relationship built with the hospitality industry. At the same time a coordinated strategy with law enforcement may have been helpful in the Monterey setting, where motivation and interest among licensees was low.

In summary the following recommendations are offered:

- Conduct a community analysis before designing or implementing a program.
- Determine the industry groups that will be the target for initial training (a broad group of servers and managers or individual businesses).
- Develop a facilitative relationship with the hospitality industry. Approach it with a problem-solving attitude and enlist its support.
- Engage in coalition building among a variety of community and industry groups. Facilitate productive exchanges and encourage ownership of the program.
- Enlist media support carefully to promote activities that will increase community awareness and coalition activities.
- Use a variety of recruiting strategies for training participation.
- Design evaluation tools to monitor the quality of the training and effectiveness of the program.

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Evaluating a Server Training Program in an Applied Setting

Louis Gliksman

Several developments have changed the way in which researchers, politicians, and programmers view the problem of drinking and driving. Acknowledgment that existing efforts, in the form of education, increased police surveillance, and criminalization of impaired driving, have been minimally effective and recent court decisions that hold providers of alcohol responsible for their patrons' behaviors both inside and outside of their establishments have forced a search for innovative ways to address this issue.

One such recent, innovative approach has been to focus on drinking in licensed establishments and to intervene at the point of purchase—when the patron orders the alcohol from the server. These programs are based on the premise, supported by the courts, that both managers and servers are responsible and obligated to ensure that their patrons do not get to the point where they can endanger themselves and others.

This paper presents the process of conducting the preliminary evaluation of the Addiction Research Foundation's (ARF) server training program, entitled "The Responsible Service of Alcohol" (Simpson et al. 1986). The emphasis of this program is on prevention rather than just intervention once a patron has become intoxicated. A full description of the study, including the results of the evaluation can be found elsewhere (Gliksman et al. 1988). The evaluation was designed to answer the following questions: Is the program effective in communicating to servers what may be very difficult serving strategies to understand, much less to implement? What are the attitudes of the servers to these obligations, and to the whole concept of server intervention? Finally, do the serving practices, monitoring techniques, and general behaviors of the servers change as a function of the training program?

Procedure

The owners and/or managers of eight drinking establishments in Thunder Bay, Ontario, were asked if they would be willing to participate in the study, the purpose of which was fully described to them. All eight establishments agreed to participate, although they were aware that their servers might not be immediately trained. The bars were representative of the different types of drinking establishments that exist in most communities, with two bars representing each type—restaurant, hotel lounge, neighborhood bar, and skid-row bar. One bar from each set was randomly assigned to the experimental group and the other to the control group. Owners of the control sites were told that their servers would be trained at the conclusion of the study. Owners and managers in both groups were informed that we would be entering their establishments at various times in the next few weeks to observe their servers, but the timing and nature of the observations were not specified. They were further asked not to inform any of their staff about the study, a request that they appear to have honored.

Although additional data were collected, the primary design for the evaluation was a quasi-experimental observational study. This approach allowed us to measure any changes in the behaviors of servers trained in the ARF program to compare these results with data collected from comparable untrained servers in the control sites. This area was where most of the problems occurred, and it will be the focus of this paper. The study involved using actors to portray situations that are covered by the program, and then observing the behaviors that servers exhibited in response to these situations. These observations were made, during 2-hour sessions, at all eight sites before and after training.

A detailed timetable for both the pretest and posttest sessions was set up to ensure that both representative days of the week and times of day were observed. Teams of actors and observers, none of whom knew which bars belonged to the control and experimental groups, were rotated around sites. This arrangement ensured that the teams did not revisit the same bar and alert servers that a study, or at least something artificial, was occurring. Although detailed scripts were developed for each of eight situations, actors were free to improvise, within the theme of the skit, as the situation demanded.

Skits were developed for the following problematic situations: age identification of a young patron; ordering too many drinks at once; ordering too often; drunken behavior and disorderly conduct; drunken behavior but quiet conduct; preparing to drive home when obviously impaired; ordering drinks while already intoxicated; and bothering others. At the same time recording sheets were developed that specified what information was to be collected for each incident and ensured consistent data collection.

Problems Encountered During Preparation and Fieldwork

The first proposal for the study was submitted in August 1987 for review and funding. Funding was anticipated by September. By November we had not heard about funding and decided to put the study off until the following year. Shortly thereafter we were told that funding would be available but that we had to spend the money in the current fiscal year (ending March 30, 1988). At this point we had to decide whether to accept the money and the condition that the funders had placed on the money. By accepting we realized that restrictions had been placed on the original design and changes had to be made.

Initially we had intended to do a followup test approximately 6 months after the intervention to determine whether the effects of the program, if any, were maintained over time. Because the money had to be spent rather quickly, determining whether any long-term impact occurred was not feasible. Thus the final design involved only a pretest and posttest and assessed only short-term impact. In addition, the abbreviated term for which funding was available meant that we had to shorten the test period, which in turn meant that fewer observation periods were conducted. This situation meant that the number of servers actually observed during the study was reduced and that we would lose power in the analyses.

ARF requires all research proposals to be reviewed for scientific rigor and then separately for ethical concerns. The process, while necessary and useful, is time consuming and in this instance lead to problems with respect to the project's timing. The Christmas holidays delayed the meeting of the ethics committee until shortly before the study was to begin. In essence this delay meant that with the first observation session of the pretest scheduled to begin the day after the review session, we were faced with a dilemma. We could allow the study to proceed and then be told by the ethics committee that we could not run the study, or we could try to delay the pretest pending formal approval.

Delaying the pretest would have resulted in a chain reaction of delays and we would not have been able to meet the deadlines imposed by the funding body. Because we had already committed resources in developing the skits and in rehearsing and training the observers, and because we had made commitments to the bar owners and/or managers, we decided to allow the study to proceed as planned and depend on our ability to convince the ethics committee of the validity of our methods. Failure to receive ethical approval would have resulted in our canceling the study at the last moment, but we felt that we had to take that chance. The need to allow time for the necessary approvals any research organization requires was highlighted by this episode.

Commitment had been obtained from the owners and managers of the experimental bars to have their servers trained by one of our staff. Most of the training sessions were conducted on Sundays when all drinking establishments in Ontario must be closed. Although all servers were told that they had to attend the training session and when it would occur, some servers chose not to attend. Their refusal meant that we had to arrange for a second training session, at our cost, and do so quickly because the posttest was scheduled to begin. To the best of our knowledge, this second session accommodated all servers not initially trained. This event illustrated that planning, commitment, and assurances do not necessarily mean that others will agree. Perhaps some initial contact with the servers would have increased the likelihood of all servers showing up when initially scheduled.

Between the pretest and posttest sessions, one of the experimental bars decided to renovate, without consulting us. When our staff appeared for the posttest observations they were met by closed doors. We had to reschedule the posttest observation for the following week when renovations would be complete. This delay meant that the observations in this location occurred 3 weeks after the training as opposed to 2 weeks for the others.

Although the vignettes were developed to correspond to the problems with which servers often come into contact, some of the behaviors were construed as being potentially dangerous to our actors. One of these, in which an intoxicated patron bothered others by confronting them at their tables was dropped at the request of the ethics committee, while the second (loud, drunken behavior) was dropped when the actors expressed some reservations. While servers may be required to deal with these issues, and techniques are discussed during the training and in the manual to address them, we were not able to determine whether servers would use the techniques in these circumstances.

During the course of the observations, actors were required to order large amounts of alcohol. Although they were instructed to surreptitiously get rid of the alcohol if they could, our observers noted that this rarely occurred. Almost without exception, all actors drank what they ordered, and in most instances were significantly intoxicated by the end of the 2 hours. Although arrangements had been made for safe transportation, this occurrence did not control for the actors' intoxication and for a potential lack of consistency across sites.

One of the potential advantages of conducting the posttest within 2 weeks of the training session was that it increased the likelihood that a new server would not be hired in the interim. In fact, one of the experimental sites did hire a new server and our actors were served by this person. Both this site and its matched control then had to be removed from the study. This event highlights a potential problem that may be faced by owners and managers in trying to ensure that their servers are all trained. High staff turnover in the hospitality industry may mean that frequent training sessions are necessary for newly hired servers.

Conclusion

The problems we encountered before and during the study were largely unanticipated. We did accept some problems knowingly when we chose to take the money with a time limit on spending it (e.g., the inability to make statements about long-term impact), but many events occurred that we did not expect (e.g., the hiring of new, untrained servers). The effects of staff turnover, management support, and training delivery—factors that were either beyond the scope of the study or that could not be answered because of the problems encountered—should be addressed in the future. Because of budget restrictions, we have been unable to conduct a followup study of the bars to determine whether the policies are still in place, whether the servers are still using the strategies advocated in the server intervention program, and, if they are, what problems they are experiencing.

The results of the study and the program's availability were reported in the media, both print and electronic, in Thunder Bay, but few if any requests for information, much less for training, were received. Apparently the transmission of information, in and of itself, is insufficient to promote a program's implementation and use. Without proactive marketing and lobbying any program is unlikely to receive much exposure, and research findings relevant for effective community programming will go unused.

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Ethical and Political Issues Encountered in Conducting Community Action Programs: Experiences from the Kirseberg Project in Sweden

Stig Larsson and Bertil S. Hanson

The Council for Environmental and Community Medicine in Malmö, Sweden, has implemented a program to increase the health of the general population. The program's approach is to integrate preventive work in partnership with primary care, specialized hospital care, and social welfare service networks, and also to involve the private sector of the economy, the public sector, and the school system. These primary and secondary programs are expected to be combined and instituted in an action research design. The program will take place in the Kirseberg area of Malmö, which is generally representative of this entire metropolitan area. Nevertheless, in terms of alcohol-related problems, the rate in Kirseberg is 3.3 times greater than in Malmö as a whole.

The goal of the Kirseberg Project is to produce a marked reduction in alcohol consumption (down 25 percent by the year 2000) and a corresponding reduction in illnesses and diseases related to alcohol in the community. We are recommending that a longitudinal study that will incorporate both process and outcome data be conducted. The use of process evaluation is an important adjunct and must be carried out in close association with the community to be useful. This evaluation will involve focusing on the participation and decision-making aspects of the local community.

The accumulation of baseline data for the outcome component of the study is the first stage. This stage will be followed by a survey of the population as a whole in order to differentiate between segments of these residents (e.g., groups of teenagers) concerning their awareness, attitudes, and concerns about alcohol consumption and social habits in relation to alcohol use. Epidemiological data will be collected and criteria for analyzing existing statistical records (e.g., police statistical reporting bureaus) will be established. To conduct a definitive evaluation of impact, a matching community to serve as a control group will be selected. The data collection, including a postal survey, will be undertaken for the control community as well. After the research instrument and design have been finalized, they will be sent to the ethics committee for further discussion and approval.

This outcome study will result in an instrument that can be used for long-term followup (no earlier than 1994 and no later than 2000). In the meantime, the baseline data collected can be analyzed to determine why the problems related to alcohol currently remain so high in Kirseberg in relation to Malmö as a whole.

We hope to use these data to generalize our results to other similar urban centers so that alcohol intervention programs can be established throughout Sweden.

A Model with Many Agents

The Kirseberg Project's objectives include incorporating a number of practices to mobilize both resource persons and the local residents through the organizational network already available to reduce alcohol consumption. A long-range goal of this process is to reduce the rates of diseases related to alcohol abuse and use. Implementation in this area will involve several activities and special information campaigns to influence norms and attitudes toward alcohol among organizational leaders and parents, who both have the capacity to lead children and teenagers to use caution with alcohol. An important focus of the program is the role of the family in the area of norm building in relation to drinking patterns and habits.

Another aspect of the program is the participation of Kirseberg residents in producing information about alcohol to counter those publications that are currently dominated by commercial alcohol-producing interests. This process can be monitored and the products of these deliberations evaluated within the context of the overall program.

Although we have received preliminary support for the project, and a number of local community organizations have decided to be actively involved from the outset, the achievement of a final project plan in which both the local community authorities and civic leaders are involved in planning and management remains a crucial step still to be attained.

In addition to the primary prevention procedures, there will also be secondary and tertiary prevention initiatives in Kirseberg. These will require the cooperation of project staff with the primary care and social welfare agencies. This cooperation will help all involved to deal more effectively with the alcohol problem and will show how the family structure can be helped and supported with treatment possibilities. Over time, primary, secondary, and tertiary preventions should develop a positive synergistic influence on each other. A full description of the project can be found in Larsson and Hanson (1988).

Community Action Research and Democratic Dilemmas

During 1988 the project had been in the implementation phase during which several contradictions or programmatic dichotomies were noted. Since we imagine that these experiences are not unique to Kirseberg or Scandinavia, good reasons exist to analyze them from a broader theoretical viewpoint. We believe that processes of community action projects can generate knowledge relevant to general community intervention programs in the health and social welfare areas, and lead to debate of political ideals and realities in the Western democracies.

Because of the fundamental role ethics and democracy play in the success and design of community action research programs, we were surprised that greater attention has not been given to these dimensions. This neglect relates partly to the fact that the political and organizational conditions differ from one country to another and from one community to another. Research on different community contexts is needed.

As a first step in this research, classifying different dimensions of democratic and ethical issues would be necessary. The following issues, presented as dichotomies, are noted here but discussed by Larsson elsewhere in this volume:

- Professional versus amateur
- Expert knowledge versus general public opinion
- Center of power versus periphery of power
- Hierarchy power structure versus bottom-to-top power structure
- Populace as object versus populace as subject
- Uniform communication (one way) versus reciprocal communication (both ways)
- Representative model versus participant model

For both the health care worker and social worker involved in various activities to expand a preventive societal framework, these oppositional questions are well known. However, such issues are seldom considered during the intervention design or in the research questions, even though they are critical from a number of perspectives. More serious consideration should be given to the moral and social considerations of the human condition in models of change.

The rapid development of and enthusiasm for interventions at the societal level have arisen because of the need to reduce widespread diseases or to resolve serious social problems. These interventions affect individuals, their environment, their interactions with others, and society at large. The different, competing approaches are illustrated more vividly in the preventive arena than in other community-based actions mainly because these actions often force us to take a stand regarding moral questions concerning both the individual and society. These approaches, stated as dichotomies, are summarized below:

- Individual as responsible actor versus individual as product of society
- Individualistic attempts versus collectivistic attempts
- Forced message (propaganda) versus free-choice messages

- Singular normative behavior versus plural normative behavior
- Expulsion of symptom (drug) versus integration of the symptom
- Treatment versus prevention
- Exclusion of treatment versus inclusion of treatment

These are fundamental ethical and moral questions, within the context of broader democratic interpretations, which we have experienced quite directly as we have tried to institute the local model of social change related to alcohol abuse and use in Kirseberg.

In the past few years we have witnessed several interventions at the societal level, implemented in the medical and public health fields. These interventions can be described as primary prevention. The greatest attention has been applied to preventive measures against cardiovascular diseases. A number of countries have formed expert groups composed of both medical and social work professionals to try to change the everyday habits of their citizens to reduce the high mortality rates from myocardial infarction and stroke in industrial societies.

The experiences from community development-community intervention programs within social work and social medicine have raised three fundamental components to consider: the human, the democratic, and the professional. It is extremely important that discussion regarding the human, democratic, and professional components should include a broadening awareness of the issues discussed above.

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Lessons Learned from Pilot Testing an Addictions Planning Framework for Ontario Communities

Robert Simpson and Paula Stanghetta

The concept of community-based planning for health services has enjoyed longstanding popularity. It is based on the assumption that members of the local population best know their service needs and are able to design the most effective responses. In Ontario, Canada, local planning bodies, known as District Health Councils (DHCs) have been developed to establish local priorities.

In order to gauge local health needs and to set priorities, DHCs undertake a variety of studies. Terms of reference are set by DHC members, one of whom usually chairs the endeavor. A steering committee oversees the implementation of the study and has representation from local stakeholders, including consumer and interest groups, service providers, and other interested parties. These studies recommend which programs, services, and policies should be developed in the district (commonly referred to as "filling the gaps") and establish priorities among these recommendations.

Although well intentioned, these local planning processes consistently encounter a number of difficulties, among them vested interests who view the planning process as an opportunity to establish territorial and funding advantage. Planning processes often fuel such maneuvering by relying on key-informant surveys to define needs; using secret votes, with no predetermined criteria, to determine priorities (unstructured voting); assigning a token status to research-oriented planning approaches and frameworks; and failing to view service delivery sectors (such as addictions) as systems.

Where these circumstances exist, the planning process is often best described as pooled ignorance, and results in disjointed growth in services. In the end, those who require services are shortchanged and scarce new funds are not allocated efficiently. Although the problems discussed are from a program perspective, they apply equally to the planning that is done for conducting community-based research projects.

This paper chronicles the experience of the Wellington-Dufferin DHC in its efforts to pilot test a new planning approach in the field of addictions. The approach is based on a comprehensive planning framework developed initially by Simpson (1983) and refined by Simpson and Rush (1985) and Rush (1987). The Alcohol and Drug Framework employs empirical methods to determine needs and structured processes to set priorities. It advocates planning on the basis of the best research findings, and represents an attempt to apply these in a community setting. The results are reported in the *Review of Addictions*

Services for Wellington-Dufferin (Wellington-Dufferin District Health Council 1987), and have been adopted in generic form as Provincial policy (Ontario Ministry of Health 1988).

The new planning process was intended not only to retain the benefits of local participation and decisionmaking, but also to overcome tendencies toward the lack of objectivity and partisan manipulation of results. The experience was judged successful in meeting these goals. In the process, however, a number of difficulties that should be considered in future planning exercises were encountered. The following review identifies these difficulties and proposes seven recommendations for future efforts.

Difficulties Encountered in the Pilot Experience

An after-the-fact review of the initial planning experience suggests two broad categories in which difficulties were encountered. We have called the first "hidden agendas," and the second "conceptual confusion." Following this descriptive section, our thoughts on how to overcome these difficulties are presented.

Hidden agendas manifested themselves in three ways. The first arose from the complex web of historical animosities that accumulated from past interactions among key stakeholders. Conflicts ranged from characterizations of agencies (such as "not concerned with health outcomes," "aggressively after turf," and "consider themselves superior to the rest of us") to individual personality traits. Most animosities came from historical scrapes and battles, and those holding them endeavored to influence group opinion through various subtle and not-so-subtle methods. We concluded that their purpose was to diminish the stature of the offending agency or individual. This tactic is particularly effective in the unstructured voting planning processes typically used in community planning exercises.

A second principal way in which hidden agendas emerged was in the area of philosophical divergences. It is well documented that the addictions field is characterized by differences both in the understanding of how problems develop and the preferred methods of addressing them. These differences showed themselves in many ways during the pilot planning process. Most notable, however, were those differences in the definition of alcohol problems; that is, whether a broad focus could be adopted or whether the problem focus should be confined to alcoholism. Subsumed within this debate were additional points of dispute about the nature of alcoholism and the appropriate ways to treat it.

Related debate was over who is best able to assist with recovery: former problem drinkers and drug users or trained health and social service professionals. Considered together, we classified these differences as philosophical, although most lend themselves to empirical verification. We based this conclusion on the observation that the facts were less a consideration in the debates than were doctrinaire assertions.

The third manifestation of hidden agendas was through nonparticipation, which was demonstrated two ways. First, one agency on the health promotion steering committee clearly did not intend to assume any role in the implementation of recommendations, despite a clear mandate to do so. The agency's representative repeatedly steered recommendations away and invariably arrived at meetings well armed with new reasons why participation was not possible. To make matters worse, the agency was one of the largest in the district and had the potential to be central to effective action.

The second way in which nonparticipation occurred involved an individual, who had poor attendance, was inattentive when present, and consistently failed to complete background readings and preparatory work. Despite this poor performance, this individual wished to express opinions, to vote, and to be afforded the same credibility as the rest of the steering committee.

Our second category of difficulties, conceptual confusion, underscores our impression that part of the disaffection for research and planning frameworks is actually an insecurity with concepts and a fear of not understanding them. Preferring to generalize from personal and anecdotal experience, these participants skeptically viewed researchers, whom they portrayed as trying to capture reality through numbers. They worked hard to establish that this task was not possible and to suggest that all research and numbers should be disregarded in developing decisions about what should be done in the community.

Some participants deemed to suffer from conceptual confusion failed to demonstrate a real understanding of the framework and how it applied to the task at hand. They treated the framework as if it were part of a preamble that should be put aside once it had been introduced. Their questions and participation throughout the planning process belied any true grasp of the framework or any ability to employ it as an ongoing tool or aid. To illustrate, one individual would regularly recommend treatment options for the health promotion component, arguing essentially that the interventions would promote health. When these suggestions were not accepted by the group, the individual would become frustrated and went so far as to suggest that the lack of support was personal rather than based on merit.

A final way in which conceptual confusion became apparent was in the application of criteria for ranking program options. As an example, participants would on occasion score options high on the effectiveness criterion despite the lack of any supporting evaluation evidence. Often they would justify this score on the basis of personal experience with the option in question. Typically the individual would cite an anecdote in which he or she knew of someone who had benefited from such an intervention, and would conclude with a suggestion to the effect that if even one person benefited, then the intervention was worth undertaking.

Collectively these difficulties seemed to have undermined the entire process at times and left us wondering whether we were really tapping into informed and well-considered opinion. In the end, we concluded that the process was more robust than its weakest links, but certainly wished that it enjoyed more attuned participation from the visible minority described above.

Recommendations for Future Exercises

As indicated earlier, the framework has been adopted as Provincial policy, and similar planning exercises to that in Wellington-Dufferin is being encouraged in the remaining 27 DHCs in Ontario. In addition, we anticipate that jurisdictions outside Ontario will appreciate its merits and undertake planning that is consistent with the framework. Accordingly we have developed the following list of recommendations that we believe will reduce the extent to which the difficulties we experienced will be repeated.

Carefully Frame the Terms of Reference

We believe that the terms of reference should be worked out by the lead planning agency. They should include the goals or intended outcomes of the planning exercise as well as the steps by which these goals will be pursued. When people are asked to participate in the exercise, it should be clear that in so doing they are accepting these conditions and are expressing a willingness to contribute accordingly. This approach sets the stage with a shared vision toward which everybody's participation is directed.

Develop an Educational Component for the Framework

We believe that considerable effort should be expended in preparing a well-designed educational package for delivery at an initial meeting. To the extent possible, all participants should be provided with a working knowledge of the framework and its implications for the planning and of how the plan relates back to the framework and the original goals. Finally, an effort should be made to integrate the anticipated perspectives of participants into the framework, demonstrating how it provides room to accommodate most major governing images—for example, the understanding that "alcohol problems" can include alcoholism, both in its narrowly and broadly defined forms, as well as any other problems that arise from the consumption of alcohol. With luck, participants should be able to agree that impaired driving is worthy of attention alongside chronic heavy drinking and binge drinking.

Introduce an Exercise To Identify Agendas

In an early discussion, we ran an exercise in which participants were asked to identify their aspirations for and fears of the planning process. We recommend that a facilitator be designated to run a similar exercise in all planning studies, using standard techniques such as reflection, clarification, and linking comments. Not only does this exercise provide participants with an opportunity to lay their cards on the table, but it also enables steering committee chairpersons to develop strategies that will accommodate the expressed concerns. We are convinced that it is better to address these concerns as part of the process than to simply hope that they will not prove disruptive.

Establish Continuing Themes in Key Areas

Certain themes, when introduced and accepted at the outset, will predictably be useful at various difficult points in the planning process. We suggest that

- Numbers and research findings be portrayed as valuable tools that can enrich the process and give greater power to the recommendations.
- An addictions system, with interventions that complement and reinforce each other, will be more effective than isolated programs, services, and policies.
- Effectiveness is a necessary criterion for the acceptance of any program option; failure to include this criterion is fundamentally unfair to intended target groups.

Establish an Orientation Toward Impact Objectives

It is critical that interventions—be they programs, services, or policies—be understood as means that are of value only insofar as they are able to achieve favorable change, or ends, among target group members. This concept orients discussion toward the merits of various ends that are intended to collectively address addictions problems. In so doing steering committees will avoid the trap of confusing activity for progress.

Orient Priority Setting Toward Consensus

Two techniques can be used to increase support for the final priorities. First, as the basis for discussing initial scores in relation to the weighted criteria, develop tables that show each participant's score for each program option. Ask those who scored highest and lowest for each criterion to share their analysis with the rest of the group, and invite group reaction and discussion. This technique should reduce much of the faulty reasoning that can contaminate the scoring exercise.

Second, in computing averages for the final priority ranking, eliminate the outliers (that is, the high and low scores) for each criterion. This technique eliminates the possibility of using extreme scores to influence unduly the average in a predetermined direction. For example, if a 10-point scale is used, an individual might be tempted to champion a particular option by consistently assigning it a score of 10 in relation to each criterion (of which there might be five) and assigning a score of 1 to a competing option. Such strategies, insofar as they depart from group opinion, will be neutralized by this technique.

Align Recommendations with Agency Mandates

The final stage of the planning process is to develop an implementation strategy for the final recommendations. As mentioned, we encountered one agency representative whose hidden agenda was to avoid assuming responsibility for implementing any of the recommendations. Upon reflection, we concluded that a better approach is simply to determine with participants which local agencies have mandates that are consistent with each recommendation. Even agencies that intend to avoid implementation roles would be hard pressed to deny consistency between a recommendation and their mandate. Once mandates and recommendations have been aligned, a number of creative approaches can be developed to inspire participation from agencies that show signs of resisting.

Conclusion

Overall, we are persuaded that the planning approach of the Alcohol and Drug Framework will yield effective plans to address addictions problems at the local level. We have offered seven recommendations that are intended to enhance the quality of output beyond the respectable levels achieved in our pilot test.

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Work Site Community Processes and the Prevention of Alcohol Abuse: Theory to Action

Martin Shain

This paper describes certain aspects of a project in which social science and local workplace theories were integrated to provide a view of alcohol use as a health practice influenced by both personal and environmental factors. This integrated theory was translated into a workplace survey of health needs and risks, which yielded results laden with implications for preventing alcohol abuse at individual and environmental levels. These implications were converted into plans submitted by work site committees to their senior managements that called for action with regard to health promotion program development relevant to the needs and risks of drinkers and with regard to environmental improvements, particularly those pertaining to the organization and design of work. These plans are currently under review by the managements of the relevant organizations and are expected to be adopted in 3 to 5 years.

As a whole, the project illustrates aspects of the process entailed when the workplace, as a community, invites third parties to collaborate in the design and implementation of more effective programs to prevent alcohol abuse and other problems associated with a variety of health-threatening behaviors. Issues are raised, however, about the appropriateness and efficiency of doing workplace questionnaire surveys where the main object is to derive implications for program planning. This paper concentrates on the rationale, development, and use of such surveys and concludes with notes on the possible alternative or supplementary use of participatory focus groups. The function of such voluntary employee focus groups is not to supply empirical personal data; rather, it is to act as validator, modifier, or falsifier of local and social scientific theories about alcohol abuse and to develop locally relevant programmatic responses.

The conceptual framework within which this project takes place originates in the tradition of action research (Lewin 1946) that has come to emphasize the following principles:

- Research is acknowledged to be by definition a biased activity in that, knowingly or not, researchers base their choices of study areas, methods, questions, and forms of analysis on values, attitudes, and assumptions derived from social learning, socioeconomic status, and disciplinary affiliation.
- Researchers' perspectives, therefore, need to be balanced by those of the people who are often considered to be the subjects of, or respondents to, studies and surveys.

- This balancing is achieved by inviting these would-be subjects to participate in the conceptualization, design, and implementation of whatever research is jointly agreed upon (Leitko and Peterson 1982). In addition, these participants become involved in interpreting the results and in determining the implications for action.
- The participatory research-action cycle is expected to repeat itself as results from the first inquiry generate further questions and as action steps are subjected to evaluation (Gavin 1985).

Action research does not pretend to be value free, nor is it atheoretical. Rather, it seeks to find common ground between the values and theories of those who see themselves as researchers and of those who traditionally would be regarded by these researchers as subjects. Thus the local theories of erstwhile subjects are treated with respect, and research goes ahead only when a negotiated common theoretical framework emerges.

Action research is an attempt to respond to the problem of patronization and condescension that too often characterizes the relationship between researcher and community. By inviting full community participation in all phases of research, action research aims to respect the autonomy of local groups and to ensure their informed consent to a process that, if implemented, will have implications for their welfare in one way or another. Better, then, that local groups be fully consenting parties not only to how and when research is done but to whether research is done at all.

This action research story begins in two places, more or less simultaneously. In Atlanta, Georgia, in 1983 representatives of the Addiction Research Foundation (ARF) and of Health and Welfare Canada (HWC) were attending a conference hosted by a third party. Through conversation these representatives discovered they shared similar views about programs for the prevention and remediation of alcohol abuse. They resolved to attempt a rationalization of program planning in this area, the status of which at that time could be broadly summarized as follows.

Health programming in the workplace aimed at preventing problems related to inadequate exercise, poor diet, overeating, excessive drinking, smoking, drug use, high stress, and poor sleeping habits is largely in the hands of people called health promotion professionals, many of whom are outsiders to the organization they serve (Roman and Blum 1988). Taken as a whole, programs designed by such professionals do not represent a planned response to the needs of employees because they are usually not based on an assessment of such needs but are imported largely on an ad hoc basis according to the whim or intuition of decisionmakers within the workplace. The result is highly fragmented programming. Compounding this problem is the fact that many health promotion programs are of unknown value, particularly with regard to preventing alcohol abuse, despite the great promise that many of them appear to hold (Shain 1988).

Workplace programming aimed at remediating problems associated with the health practices outlined above is concentrated predominantly in two loci within organizations: the medical department (if there is one) or the Employee Assistance Program (EAP). Sometimes the EAP is itself part of the medical department but this practice appears to be in decline (Shain and Groeneveld 1980; Steele 1988). EAPs are considered the major workplace response to alcohol abuse, as well as to an increasing variety of emotional, domestic, financial, and other problems, all of which may at some point have an adverse impact on employee health and productivity (Shain et al. 1986). EAPs exist in many forms, but their common feature is to provide employees the means by which they may obtain help for a personal problem, usually at the employer's expense, through some service contracted either within the organization itself or with a third-party provider in the community.

Although EAPs are at the center of workplace responses to alcohol problems at the remedial level, their value has been challenged on numerous grounds, including low penetration rates relative to the populations at risk, selective coverage of lower status employees, lack of relevance to women, and questionable effectiveness in terms of their rehabilitation of problem drinkers. It has also been suggested that EAPs have difficulty in achieving really early identification of people with drinking problems. Part of the difficulty here may be that too much is expected of EAPs. They may be the wrong tools for the job in that their clinical orientation and intensity may be inappropriate for people with emerging or situation-dependent drinking problems.

Elsewhere, at more or less the same time as the Atlanta conference, certain work site committees charged with the overall monitoring of their EAPs were contemplating the shortcomings, as they saw them, of their organizations' current responses to alcohol problems and to other health-related difficulties. The committees in question were, and are, made up of management, union, and staff representatives. Like ARF and HWC, these committees perceived the field of health promotion programming to be fragmented and unorganized. However, they tended to see EAP as the force that would eventually organize and rationalize the diffuse efforts of HPP providers, a point on which there was some disagreement as ARF and HWC began to discuss these matters with the work site committees.

The concerns of these committees were brought to the attention of the original ARF and HWC team by other ARF staff whose responsibilities involved them with the workplace largely around the development, installation, and maintenance of EAPs. In this way, an ongoing dialogue began that was and continues to be characterized by a constantly expanding vision of the influences that bear on alcohol use and a wide variety of other health practices and conditions.

Throughout the history of this project, the ARF/HWC team has seen the work site committees as active partners in the process of problem identification, needs and risk assessment, and intervention development. During the first meetings between the agency team and the work site committees, it became clear that both parties saw the logic of doing employee needs and risk assessments to determine the basis for any action that might be recommended to senior management. The questions were what such an assessment should contain and how it should be done. The ARF/HWC agency team initiated the discussion by presenting a draft questionnaire to a work site committee in one organization, suggesting that this instrument form the basis of a survey of all employees. This questionnaire dealt with needs and risk in relation to a wide range of health-related areas, such as exercise, sleep, eating, weight control, smoking, drinking, drug use, stress management, and blood pressure control. Needs were determined primarily by asking respondents what if anything they thought they should do in the areas just listed in order to maintain their health or to improve it. Risks were assessed by asking employees to report their actual practices in the same areas.

This approach to health needs and risks did not find favor with the work site committee that first reviewed the draft questionnaire. Its view, or the view of most of its members, was that health consists of more than what or how much people eat, their level of activity and fitness, their smoking and drinking, and so forth. These factors were considered important but so too were a range of factors not included in the questionnaire, which involved the working environment.

Two aspects of this environment were implicated in the maintenance, promotion, or defeat of health in this regard—namely, the psychosocial and the physical. Psychosocial issues were seen largely in terms of the stresses that result from the organization and direction of work: high pressure, deadlines, schedules, unrealistic expectations, excessive supervision, inadequate supervision, poor feedback on performance, other communication problems, isolation, discrimination, harassment, and many others. Physical issues were seen mainly as occupational health and safety conditions pertaining to air quality, heat, light, noise, exposure to toxic chemicals, electrical and mechanical hazards, space limitations, and, again, many others.

These psychosocial and physical conditions were considered to directly influence health and health practices in that smoking and drinking, for example, could be seen as attempts to deal with the adverse effects of stress and with concerns about safety. The work site committee's view, as just described, amounted to a local theory (Elden 1986) of how alcohol and tobacco fitted into a general paradigm of health and health practices.

This local theory about influences on well-being was familiar to the ARF/HWC team in another context as the Biopsychosocial Model of Health (Alonzo 1985; Mechanic 1986). This model sees health as the product of the individual's transactions with the environment. Indeed the model is based on the premise that individuals deploy their biological, psychological, social, and economic resources in efforts to adapt to their psychosocial and physical environments. As such this theory is more sophisticated than the one the ARF/HWC team had presented to the work site committee. This theory has broader implications for intervention in that the environment falls largely within the employer's responsibility and authority, while health practices tend to be seen as the employee's responsibility. We (the ARF/HWC team) had anticipated that if the issues associated with environment were to be tackled at all, they would be addressed gradually, perhaps after presenting results from a narrower survey focusing on health practices. The work site committee would have none of this and wanted the environmental issues up front.

The questionnaire survey, based on this altered perspective, was in some ways a success. It did provide a reliable picture of the various influences on wellness and on alcohol use. But it really did little more than confirm what the work site committee and the ARF/HWC team had come to believe before the study was done, and it took several months to produce the results.

The major implications of the findings for action were that alcohol use is influenced by interactive pressures emanating from work and from home; heavy alcohol use is more common among occupational groups whose members perceive themselves as having little influence over their own work and their own health; and heavy alcohol use is negatively associated with wellness through its partnership with smoking.

In retrospect these conclusions possibly could have been reached more quickly and more efficiently by other means, although the results would not have had scientific validity in the usual sense. Once the ARF/HWC team and the work site committee had determined the influences they thought were relevant to alcohol use and to wellness, they could have validated, modified, or falsified their local theory within that environment by conducting a series of participative focus group sessions among employees. The object of the exercise would have been to determine the currency of the theory in the work force as a whole. Thus, the result would have been a verdict on the local acceptability of the theory rather than an empirical test of it. But employees would have been very much a part of the process, would have felt some ownership of it, and might have bought into the planning phase that was intended to flow from the survey results.

How much and what kind of information then is required to serve planning purposes? Currently as a result of conducting an elaborate and costly questionnaire survey, we can point to what we believe to be key influences on alcohol use in the context of the workplace. The planning implications of these findings, however, are probably little different from those that would have emerged had the local theory been tested through participative focus groups, in that both can assign relative weights to the influence of environmental and personal factors in the precipitation of heavier alcohol use. However, workplace committees and planners need not produce results publishable in scientific journals; they only need enough credible data on which to base programs or interventions. Further the method of inquiry should be resonant with the planning process that is intended to result from it. Questionnaire surveys, even if participatively planned, are somewhat remote, sterile, and potentially alienating methods leading to results that often lack immediacy and human appeal. Focus group inquiry is personal, alive, and easily converted into a planning format. Perhaps, in the future, more respect should be paid to these live techniques. Properly informed by sound preparatory work to determine the nature and limits of an inquiry, these techniques have much to offer in immediacy and relevance—key components in any effective planning process.

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Debate and Action on Lifestyle Issues in the Finnish Trade Union Movement: Experiences of an Action Research Project

Marja Holmila

This paper deals with the two phases of a way-of-life project conducted with the Finnish trade unions. The underlying idea of the project was to seek ways in which the trade union movement might influence people's way of life and make it easier to discuss such matters in the context of a trade union. By critically looking at prevailing cultural patterns, the study might provide a means to understand and to affect the essential characteristics of the participants' everyday lives. Better health would be one objective, among others, of the project.

The project started as an experimental action research course at the beginning of 1982, and is, in some fashion, continuing. The first phase took 2 years to complete, the experiences of which are reported elsewhere (Holmila 1985). The activities were then continued with a larger group and with somewhat different goals. The second stage also took 2 years (Hietanen 1988). The trade union officials have recently recommended that the organization should continue the discussion on lifestyle issues as part of the trade unions' educational activities.

The employees who were to take part in the first stage were chosen from four different parts of Finland and eight separate factories—metal industry workers, paper industry operatives, and textile and clothing industry workers. While the project also endeavored to stimulate action, its main aim was to encourage thought and discussion about the issues raised. Four main themes of discussion were found when the research notes were classified.

The first of these was the relationship between differing segments of the working class. The second theme was the organization of the trade union movement, in particular, the links between the activists and the legions of passive rank and file members. The third topic was the community, which offered opportunities for contact between places of employment. The fourth theme revolved around the societal aspects of the problems of the individual. For example, drinking problems were looked at in the light of human relationships.

At the second stage the project became more closely a trade union project. The courses were planned and led by teachers at the trade unions' own school.

The slogan for the second stage was "Courageous Life" and the goals were defined in the following way (Hietanen 1988):

- To give information and widen the discussion on the questions of way of life (cognition).
- To create small group action at the working sites and in the trade union (action).
- To support one's ability to master one's own life and to change it (mastery).

The project's two stages were two parts of one process. Both stages attempted to create something new and make the participants look critically at their lives. While the first stage attempted to consider everything at the collective level, mainly in relation to the working site or the trade union branch, the second stage was more individualistic. Growing realism probably caused the change in emphasis. However, the shift was not completely deliberate.

Human relationships were important topics throughout the process. First, the organizers emphasized that workplace relations should be discussed. Yet family relations were considered more interesting and more important by the participants.

During both stages, criticism of typical trade union activities were discussed. In the first stage, the women's position in the trade union movement generated a lot of heated discussion. During the second stage, trade union activities were often looked at from the individual's point of view where trade unionism was seen as a hobby.

During the first stage, health-related issues were emphasized, and one of the main meetings was dedicated to those issues. Alcohol use, smoking, and mental problems were discussed, as well as the networks for help and treatment. During the second stage of the project, health issues were not emphasized as heavily. Yet many participants mentioned their own healthier habits as the most important change caused by the project. Health services, treatment, and mutual help in mental or alcohol problems were not discussed at the latter stage of the project—perhaps the clearest shift that took place during the process. The reasons for the shift can be found in the organizational changes that took place in the beginning of the second stage.

Goals and Problems

We can look at the goals and problems of the project from three points of view.

- How did the project succeed in its effort to combine research and action?
- How successful is health promotion in the trade union context?
- Is it worth conducting research in this kind of setting?

How Did the Project Succeed in Its Effort to Combine Research and Action?

The fundamental principle of action research is that the people on whom the research focuses are participants in the research. They must be the subjects, not the objects of the study. We have discussed elsewhere in this volume the dialogical[1] nature of action research and the problems this type of research creates.

How Successful Is Health Promotion in the Trade Union Context?

How useful is the collective approach of health promotion in a modern, individualistic society? At the outset, the trade union project seemed to show that a shift toward a more individual approach is inevitable. Health-related questions do not find collective expressions. It was hoped that in the trade union context the discussions would stress solidarity toward those workmates who have personal difficulties. However, this approach did not seem to work very well. Trade union people were not greatly interested in promoting the rights of alcoholics or helping those with mental disorders, for instance. Even when participants showed interest, the general feeling was that the possibilities and means for helping others were lacking. Also, participants felt the employer was responsible for such things.

The experiences showed that the more the trade union ruled the action, the less attention health issues received. A strong voice from outside specialists may be required in issues related to health. Work-life organizations can all too easily solve their health-related problems by excluding the unhealthy members.

Of course, health promotion is possibly most effective when conducted in a very wide context. Talking about a "courageous way of life" would thus be an excellent health promotion. However, such wide formulations are likely to be only short lived. Motivation for keeping up the activity disappears quickly. Also, controversial and uncomfortable issues, like alcohol use or smoking, are likely to be forgotten without special support from outside.

Is It Worth Conducting Research in this Kind of Setting?

Certainly all health promotion projects do not need to be evaluated. Reasons for getting into the tedious and expensive venture of research should be specified. What were the reasons for connecting research with this particular project?

Both the researcher and the organization showed active interest in having research be a part of the project. The trade unions felt that the financial supporters wanted evaluation. The unions also thought that having researchers' help in running the experimental project would be useful.

The researchers, on the other hand, were interested in the methodology of action research and saw the project as an opportunity to use it. Also, the approach seemed to provide a way out of the problems of the traditional evaluation of health education, which were pointed out in earlier studies. A third reason for the interest was that the project provided an opportunity for getting inside the factories and inside the trade union movement—access that had often been denied in the past.

These expectations were mostly satisfied during the project. The greatest disappointment, however, was connected with the use of action research methodology. The energy needed to run the project, to take part in the meetings, and to plan the courses was demanding, although not impossibly heavy. The negative experience was not caused by the amount of work as such, but by the feeling that this energy was not rationally used. We often believed a person educated in health promotion would have succeeded much better in running the project, and that a good piece of research would have been possible without our being engaged as active promoters of the project. The prolonged research process would have been worthwhile if the project had fully succeeded in its attempt to root dialogical health promotion in the trade union movement. Disappointments in this respect added to my perception that the experience was somewhat wasteful of research energy.

Notes

1. Dialogical refers to something, in this case a process, characterized by dialogue.

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A Programmer's Perspective on Implementing a Drinking and Driving Countermeasure at the Community Level

Regina J.E. Caverson

Introduction

Within countermeasure programming, a new approach using social marketing techniques has emerged. Most countermeasure strategies have traditionally been aimed at the drinking driver, but the total of drinking drivers pulled over at roadside spot-checks is small relative to the number of drivers stopped (Vingilis and Vingilis 1987). By looking for drinking drivers through actions aimed at all licensed drivers, the advocacy messages and strategies urging drivers not to drink and drive possibly may no longer be appropriate to the majority of drivers.

The Addiction Research Foundation of Ontario, in collaboration with the Sudbury Regional Police Force, implemented a new countermeasure program, the Sober Driver Program. The program is directed at nondrinking (sober) drivers stopped at roadside spot-checks and seeks to reinforce their law-abiding behavior by thanking and rewarding them with a plastic license folder. Concurrently, an extensive media campaign informs the community of the program. After a 1-year test period the program was evaluated by a survey of the community and police. Both groups responded positively (Caverson et al. 1988).

This paper will discuss the challenges faced by the program manager in implementing and evaluating this countermeasure. In examining these challenges the problems faced, new opportunities that emerged, lessons learned, and future implications are also addressed.

Implementation Challenges

As with any new intervention, the Sober Driver Program encountered a variety of implementation challenges in working with police, media, and sponsors.

Police

It was apparent that internal police force issues influenced program implementation. Fortunately, the original commitment and contracting agreements with the chief of police and the persistent dedication of the community services officer (CSO) to the intervention design allowed the program to continue with only a few minor changes that did not jeopardize the integrity of the intervention.

Traditional policing vs. prevention. In this police force some officers believed in an enforcement approach only and others believed that policing could not conceivably stop all crime and therefore supported prevention efforts. There were also officers who agreed with prevention but at times slipped back into an enforcement posture. This concern arose when some of the officers who had contact with media had difficulty conveying the prevention philosophy of the Sober Driver Program to the public and reverted to using traditional, negative messages that created some confusion about the program in the minds of the public. The chief of police, however, was able to rectify this situation by reinforcing the philosophy of the program and designating appropriate personnel as media liaisons.

Complexity of internal structure. Previous contact with one of the police force's CSO's enabled the programmer to access the Sudbury police force for the project. Commitment and support were also required from the chief and were obtained with the CSO's assistance. Some difficulties were experienced, however, because the department responsible for implementation (traffic) was not involved in early negotiations, and senior personnel in that department changed during the pilot phase. These factors did not create initial concern until a newly appointed traffic sergeant did not assign officers as frequently to spot-check duty as had been done previously. Efforts were made by the CSO to subtly encourage the traffic sergeant to increase spot-check frequency although the CSO had no authority to order the sergeant to do so. This situation resulted in a 3-month loss of spot-check data. Only after the chief of police was apprised of the situation was it rectified and manpower reassigned.

Successful implementation required the following: being sensitive to the internal structure of the police force; ensuring that protocol was always followed; encouraging communication between departments; and seeing that everyone involved with the program was kept informed. The police assisted by setting up a small internal committee to facilitate this process.

Police language. A relatively minor challenge of the project was awareness of the language used by officers. For example, information sessions on the program for traffic officers had to be entitled "orientation" and not "training." As another example, the term "sober driver" needed clarification and agreement on its use by members of the police force.

Perceived manpower shortage. Although a shortage of manpower was at times cited as the reason for not conducting spot-checks, the underlying constraint was a matter of police commitment to reorganizing staffing priorities.

Data retrieval. Although data retrieval relates to the evaluation, the problem that generated some data retrieval difficulties arose with the program implementation. Retrieving the data the evaluator wanted from the collaborating police force was not easy because the force had not yet computerized its records, necessitating manual data retrieval and making data gathering difficult. In addition traffic officers conducting spot-checks were required to collect data. Inconsistencies in the way information was recorded created some problems for the researcher when trying to chart spot-check information. Last, even though commitment was received from the control community's chief of police to collect similar data, their statistician did not fulfill the agreement.

Product control. As the sober driver folders became popular, maintaining control over them became essential. The program manager was concerned that if folders were given to anyone requesting them, then the incentive given at spot-checks would be devalued.

Public image. The police became involved with the program not only to continue to detect impaired drivers but also to develop a positive public image through the spot-checks. This factor was one of the complementary challenges of the Sober Driver Program. Although the program manager had not initially considered the significance of this factor, the program's positive nature resulted in police support and commitment as well as appeal to the community.

Media

Several challenges were encountered in working with the local media.

PSA production. Because the positive focus of the program was different from the typical "don't drink and drive" messages, producers from both radio and television felt the Addiction Research Foundation and police would be better suited to write the scripts. All the public service announcements (PSAs) needed to be simple, well spaced, and positive to support the philosophy of the program.

Media mix. Only the electronic media responded to an offer of program involvement. This response was partially because of their general support for the Addiction Research Foundation, but may have also been because of Canadian Radio and Television Commission broadcasting guidelines that require electronic media to allot a certain amount of air time to public service messages. The same rule is not applied to print media.

Newscasts. One of the challenges faced in working with media was to ensure accurate reporting, particularly in news stories. The news media, in reporting on the Sober Driver Program, confused it at times with another countermeasure program and reported it as such. Also, reporters often went to their own personal contacts within the police department so that the person with the best program information was not always approached.

Community Sponsors

Financial sponsorship was not difficult to obtain. Because public interest in drinking and driving has become a community concern, businesses were eager to assist in return for credit for program involvement in PSAs and on the folder.

Evaluation Challenges

Spot-Check Data

Originally data were to be collected at spot-checks conducted by police for 1 year. These data were to be matched against data from a control community. Negotiations were held with the chiefs of police of the two communities, and assurances were made to the researcher and program manager that spot-checks and data collection would occur.

Data from the test site were also to be overlaid on the frequency of PSAs during the media campaign to evaluate the direct impact of the PSAs. Unfortunately, this analysis could not be done because data collected by the test community was inconsistent and sporadic during a 3-month period; the police statistician from the control community did not collect the required data; and the media were unable to provide an itemization of the frequency of PSAs. With the information available, we were, however, still able to show that the majority of drivers stopped at spot-checks were identified as sober by the traffic officers on duty. In fact, during the course of the entire project, only .06 percent of all drivers stopped were charged with impaired driving, while over 80 percent of all drivers received the plastic license folder. This result satisfied the objectives of the program manager and police whose primary interests were the number of sober drivers passing through spot-checks.

Community Survey

The survey of community reaction to the program presented one of the greatest challenges to the researcher. Although the number of respondents necessary for a valid telephone survey was specified and the random digit dialing procedure was outlined in detail, meeting the requirements of the survey proved difficult and a smaller sample than desired was obtained. In addition, the timing of the survey presented some problems.

Originally, the survey was to be conducted in October 1986. Negotiations over the questionnaire design, however, took 3 months longer than anticipated. By the time the survey was conducted, it was December 1986, a time when most communities in Ontario were saturated with drinking and driving messages just before the Christmas season. As a result, although the data collected through the telephone survey indicated community receptivity to the program, some confusion existed with other drinking and driving campaigns just commencing.

Police Survey

The chief of police suggested that officers be surveyed for their opinions and ideas about the future of the Sober Driver Program. As with the community survey, negotiations took place between the police, researcher, and program manager with regard to the questionnaire design. From these discussions it was apparent that the police were concerned with the public image of their department and how the sober driving message could be improved. Three-quarters of the 200 officers on this force received the questionnaire and just over one-half of the surveys were returned. Although the chief was somewhat disappointed in the response rate, the results satisfied the researcher as an adequate sample of officers. The results of this survey corroborated those of the community survey in that officers who responded indicated support for the program, felt it improved public relations, and wanted the program to continue.

Implications

The minor setbacks and challenges of implementing the program were always viewed as opportunities to strengthen the program model. Each setback, for example, provided insight into potential problems that might be experienced with replication. The following points are offered as guidelines for introducing such a program.

Contracting

The importance of negotiating and contracting with senior personnel cannot be overestimated. Often program managers tend to use access points lower in the hierarchy and fail to reach the most senior person. Subsequently, if problems are encountered with implementation, there is no senior official to assist the program. Throughout the implementation of the Sober Driver Program, a written, contractual arrangement provided essential support and ensured that everyone continued with the plan as agreed.

Illustrating Program Benefits

Any program must offer something to the various participants. In the case of the Sober Driver Program, each person associated with the program had his or her own objectives that we believe were met through the implementation and evaluation.

Ensuring Program Consistency

The uniqueness of the positive approach used in the program was key to promoting it to police. However, always maintaining the positive approach was difficult, because the various collaborators sometimes reverted to traditional scare tactics and relied on drinking and driving crash statistics, negative messages, and such when discussing the program. A great deal of work was needed to keep program staff thinking of the positive messages every time they spoke of the program to keep the community focused on the goals of the program and to ensure that everyone involved was aware of the terminology (e.g., BAC, sober driver), particularly when new police officers, media, and community sponsors became involved.

Dealing with Personnel Changes

Personnel changes were both positive and negative. On the positive side, new people created new energy and ideas for the program, yet on the negative side, they also required a time-consuming orientation period. Staff changes also created some minor lapses in data collection and media coverage.

Recognizing the Importance of Collaboration and Finding Access Points

As with any countermeasure, the program needed to be viewed as a collaborative venture. As a result everyone involved benefited as the community saw the effort as a united one. With collaboration, a program manager needs to identify key organizations and find access points at various levels in the hierarchy of an organization. However, agreements to implement ultimately must be formally negotiated with senior staff.

Crediting

Throughout the program ensuring that all the people involved were given credit for their input was essential. Acknowledging people's contributions to the program not only ensured continued support but fostered good working relations that may be useful for other programs.

Being Aware of Competitive Community Forces

Competitive forces can undermine prevention efforts and must be taken into account when planning a program. For example, in the Sober Driver Program, once the electronic media became involved, the print media was reluctant to help, which may have weakened the intervention. Another instance of unanticipated competition arose when a second police force of overlapping jurisdiction strongly pursued a countermeasure program, producing recognition problems for the Sober Driver Program.

Timing

Timing the media campaign, the spot-checks, and the evaluation was critical. For example, the community survey was conducted at a time of the year when many drinking-and-driving messages are provided, and this may have created some message confusion which may have confounded the evaluation.

Research Support

A valued resource for the program manager was access to the Addiction Research Foundation's Community Programs Evaluation Center, as well as the services of a scientist who specializes in evaluating health-promotion programs. Anyone attempting to pilot test and evaluate a program model should endeavor to have access to such expertise.

Maintaining Momentum

Although the program has continued beyond 1 year, maintaining the momentum of the program has been difficult for the coalition, yet strategically important.

Marketing the Program

Because of the positive nature of the program, a number of communities demonstrated interest in the Sober Driver Program before the evaluation was completed. Erring on the side of caution, the program manager has attempted to market the program model carefully and monitor replication because of the risk of having the program misunderstood and incorrectly implemented.

The Sober Driver Program has indeed presented the program manager with many challenges. Aspects of the program illustrated the difficulties inherent in coordinating a variety of interest groups in planning, implementing, and evaluating an intervention. Without cooperation among the key interest groups, the success of such community programs would be impossible.

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A Grassroots Approach for Reducing Petrol Sniffing Among Aboriginal Youth: Some Problems and Possible Solutions

Ernie Lang and Marian Kickett

This paper reports on lessons learned during the course of a community action project, with particular reference to the process of implementing the project and the problems encountered, and to changes made during the project to resolve such problems. The program was started in 1987 to combat petrol sniffing among Ngaanyatjarra Aboriginal children in eight small settlements (total population approximately 1,300) located in a remote desert region (96,525 square mile) of Western Australia.

Petrol sniffing among children in this region has been a major problem since the early 1970s (Senate Select Committee 1985) despite sporadic, well-meaning, but poorly conceived and implemented efforts by various government departments. Following consultation with the Ngaanyatjarra people, the Western Australian government set up a Working Party in November 1986 to help them develop and run their own program to combat the problem. The Working Party, which is predominately Aboriginal (three of its members being Ngaanyatjarra), has worked closely with the Ngaanyatjarra people to develop strategies to combat petrol sniffing.

The program has three major components: research to provide data for program evaluation; community education, including a health education component dealing with the harmful effects of petrol, and a school-based component dealing with peer group pressure, risk-taking behavior, positive goal setting, raising self-esteem, and importance of family relationships and friendships; and a series of workshops, the most important of which is the community workshop around which the objectives of community action takes place.

The underlying assumption of the program is that the imposition of a dominant European culture has gradually disintegrated Aboriginal culture, demoralized the people, and eroded their capacity to respond to and to cope with problems. Petrol sniffing is seen as one symptom of this process. The program aims to overcome this process of demoralization by helping people regain their self-esteem and self-confidence so that they are able to set goals and develop strategies to combat problems and prevent them from recurring. This approach is based on the beliefs that local people are the best placed to identify and understand local problems, are the best equipped to deal with them, and should be involved in developing and implementing their own programs.

While changes in petrol sniffing to date are promising (Colliver and Genat 1989), the changes cannot be conclusively attributed to the program or the activities of the Working Party. The reasons for this uncertainty relate to problems encountered in the community action component and in evaluating this aspect of the program.

Community Action: Process, Problems, and Countermeasures

Process

The type of community action to be undertaken was based on an understanding of what was happening in the region and by past experiences of Working Party members in working and living in Aboriginal communities. Participant action research was judged to be best suited to this project, and intervention should be at the settlement level. The first step was to consult with the Ngaanyatjarra people to determine what they hoped to achieve. The outcome of these discussions served as the major aim of the project—to restore pride and self-esteem by getting people to work together to combat petrol sniffing.

Given that the Ngaanyatjarra are mainly culturally distinct in language, kinship, tradition, and locality, they were perceived as being relatively homogeneous. The non-Aboriginal members of the Working Party believed that such homogeneity implied that a systems approach, with the settlement being the major system, was preferred. Thus, a deliberate decision was made not to intervene at the level of the family or the individual (an approach adopted in a similar project elsewhere in Australia) because dysfunctional families acting alone were assumed to be incapable of effecting any real change or taking any effective action against family members who sniffed petrol. The systems approach would involve working closely with each settlement to develop problem-solving and team-building skills through an ongoing series of community workshops.

During the first 12 to 15 months of the project, the enthusiasm of the people and their sense of urgency for action reinforced the belief among members of the Working Party that they were prepared to work together. The Working Party continued to respond to these signals by facilitating the workshops to develop community cohesion and to generate priorities for action.

Problems

Some considerable time elapsed before the Working Party realized that the perceived enthusiasm and urgency did not reflect a willingness for community action or result in people actually working together. What had in fact occurred was that the responsibility for dealing with petrol sniffing had been placed on individual families and with the community wardens. The main reason for this occurrence turned out to be cultural.

Traditionally clear divisions of responsibility exist for "growing-up" children. The mother is primarily responsible for both boys and girls from birth until the children are around 9 years old. After that the father or uncles become responsible for boys until their initiation into adulthood around age 13. Girls remain the responsibility of mothers and aunts. Most sniffing commences between the ages 9 and 13 and almost always occurs among boys. Therefore the men obviously were neglecting to carry out their traditional role in disciplining the boys.

Two reasons surfaced as causes for this neglect. First, because the problems associated with sniffing are nontraditional, the men did not know how to respond, either through discipline or in a caring capacity because, in the latter instance, men are not traditionally carers. Second, the people as a whole are afraid to pursue sniffers (that is, chase them) because they believe this action may result in the sniffer's death. The result is that, in addition to their caring role, mothers and aunts have been forced into the nontraditional role of disciplining older male children and, in some cases, young men, an action that brings them into conflict with their culture. The resulting tensions surface as intra- and interfamilial conflict that prevents the people from working together. The fact that after 2 years the Working Party was unable to establish even a single core working group in any one settlement was testimony to this situation.

Lessons

Three important lessons are to be learned from this process. First, the settlement, or community, is not the primary system with which to work because, contrary to earlier opinions about homogeneity, the settlements in fact comprised a number of diverse groups, such as traditional people, Christians, old people, young people, and various language groups. Within these groups, animosities and tensions effectively prevent the growth of the cohesion necessary for community action and community development.

Second, the decision to sidestep conflicts within and between families has been proven wrong because it now appears that the family, not the settlement, is the major system. The challenge then became one of finding ways to overcome the tensions and conflicts between families that generated real fears of retribution through physical attack or sorcery, which in turn results in their turning away from problems to avoid losing face. Because petrol sniffing is a major cause of these tensions and conflicts, a strategic reconsideration by the Working Party and further consultation with the people were required to come up with an alternative strategy. This strategy is discussed later.

The third lesson learned stems from the failure to build evaluation into the program from the outset. No effective measures were taken to evaluate the outcomes of the community workshops other than those embodied in the methodological approach. The exclusive use of this approach meant relying on participants for the evaluation, and produced the possibility of misinterpretation of messages, which appeared to be the case when the Working Party assumed that the sense of urgency for action was a signal that people were prepared to work together. Had some objective external evaluation been carried out, the conflict between the expressed aims and the actual outcomes possibly might have been detected much earlier.

Modifications and Complications

The first changes to the program involved concentrating more on working within a systems approach to identify what was happening in terms of relationships within families, settlements, and the wider Ngaanyatjarra community, and paying more attention to differences within these systems. At subsequent community workshops, these matters were addressed in a way that enabled people to better understand what causes conflict and what measures can be adopted to avoid and to overcome it. The technique used was a process of spatial mapping.

As various points emerge during the course of discussions they are mapped on large sheets of paper using traditional-style Aboriginal pictures and diagrams and some written words. This map enables people to see how problems such as petrol sniffing are caused by many different forces and, more important, how these forces interlink to form a pattern. Part of this process involved mapping the responsibilities of the extended family, which helped people see that parents on their own cannot deal with sniffing children and created an awareness that some families need wider community support to overcome problems associated with sniffing. Although all the people may not work together, the map does appear to give them a foundation of common purpose from which they can work to settle differences if and when they arise.

Another change introduced was to incorporate outcome evaluation into the workshops. The measure most likely to prove effective in this regard was agreed to be the use of key informants because this measure was best suited to the methodological approach. Furthermore, the measure was in accord with the wishes of the people to be actively involved in running their program. Nevertheless problems with this approach soon became apparent.

To obtain information from key informants, two processes were agreed on. First, it was decided to carry out structured interviews with two non-Aboriginal residents during each visit to the settlements by the Working Party. One problem with this approach was maintaining regular, though periodic, contact with the informants, for not all settlements were visited during each trip to the region. This situation meant that any data gathered would lack continuity and consistency, although this problem could possibly be overcome by introducing a self-administered mail-back questionnaire.

The second set of key informants were the senior Aboriginal persons in each settlement who helped explain the people's perceptions and attitudes about the efficacy of the program and the role played by the Working Party. To date, two major problems have been encountered in obtaining data in this way.

First, because of social and cultural factors, it is not always possible to locate these informants. For example, they may have gone hunting or traveled several hundred miles to attend a ceremony or a football match. So, as is the case with non-Aboriginal informants, a lack of consistency in any data collected is likely to exist. However, because these people's views are critical to the program's evaluation and they live in a manner that makes this form of data collection difficult, there appear to be few practical alternatives for obtaining the required information.

The other main problem with this approach to data collection is that the very act of questioning traditional Aboriginal people about what they think of abstract concepts is problematic, as was demonstrated when an anthropologist, who at the time was assisting the Working Party, attempted to collect information using a series of questions phrased in simple nonthreatening language. She found that in many instances the people were unable to fully understand what they were being asked and, as a consequence, the resulting responses required careful analysis. This type of problem is compounded by the lack of experienced personnel to undertake such tasks, which underlines the earlier comment regarding the failure to incorporate evaluation into the program from the outset. Had an evaluator been employed as a member of the Working Party, many, if not all, of these problems may never have developed. Or they would at least have been dealt with much earlier.

Finally, one other unique problem was encountered during the project, a problem that stems directly from the original decision reached between the Ngaanyatjarra people and the Western Australian government, namely, that if the Ngaanyatjarra people would acknowledge ownership of the problem a Working Party would be set up to assist them in overcoming it. Ultimately, the prevention program is to be handed over to the Ngaanyatjarra because they would have had a significant say in its development and implementation. In other words, their wishes with respect to when, where, and how various strategies are to be employed have to be acknowledged, just as their wishes not to do anything, even if previously planned, have to be respected. This latter point, the process of not doing, poses an ongoing problem for the program.

Because of a prolonged period of customary law business involving major initiation ceremonies among a number of related language groups, during the second half of 1988 the program of community workshops was disrupted for a number of months. This disruption broke the people's focus on previously planned actions as they left their settlements for weeks at a time to attend ceremonies hundreds of kilometers away in South Australia. Consequently, the sustained intensive contact necessary to support the process of working together was not maintained.

Similarly, the advent of the football season heralded prolonged mass movement between settlements in both South Australia and the Northern Territory, as well as within the immediate region in Western Australia, with consequent disruptions to planned activities. At this time outbreaks of petrol sniffing may occur as sniffers from various settlements congregate at one location. This situation can also facilitate the spread of sniffing as new members are recruited into the core group.

Unfortunately little, if anything, can be done within the constraints of the program to overcome these problems. The rights of the people to engage in traditional ceremony must be respected, just as their love of sport, particularly football, must be accepted and tolerated, although in both instances valuable time may be lost in combating sniffing. This lost time ultimately may result in some sniffers dying. However, it may also be possible to devise some novel strategies based on the positive aspects of these people's enthusiasm for football to counter the problem of sniffing before it occurs.

Conclusions

Two very important lessons are to be learned from this project. The first is that unless evaluation is built into the program from the outset, with the evaluator a part of the project team, numerous ongoing problems, both in running the project and in convincing outsiders of its efficacy, are likely to exist.

The second lesson is that no matter how homogeneous a community might appear, it cannot be assumed that this similarity will translate into community interest or community solidarity in the face of a problem that has the potential to divide even as culturally distinct a group as the Ngaanyatjarra. Thus if the grassroots approach to community action projects used in this instance was not viable in such a small, relatively isolated, and close-knit community, the likelihood of success in a more culturally diverse community, irrespective of its location and size, is even less. Ultimately, however, the efficacy of any future projects will depend on how much has been learned from past mistakes, and on an approach that, from the outset, involves the program's recipients in the planning and implementation.

The challenge, then, is for project designers and researchers to devise appropriate models for community action projects. These models may range from variations of the grassroots approach based on lessons learned from this and similar projects to alternatives, such as a project imposed on communities by an outside agency. With respect to the latter, there may be lessons to learn from the "mega" projects that depend on sophisticated computer models and that are imposed on communities from above, as opposed to originating from below.

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Polish Community Response to Alcohol Problems Study: Fluctuating Visibility of the Problems

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The Polish research project on community response to alcohol problems was undertaken as part of the European project in 1987. The project looked at the extent and prevalence of alcohol problems in Poland and at the community response they generate. The study has detailed the general characteristics of the country, as well as the characteristics of the problem in selected local communities. The study covers a number of relevant issues, including the analysis of statistical data concerning the communities under study; a population survey in the communities; interviews with the staff of local agencies dealing with alcohol problems; a presentation of the research findings to the local communities, as well as a determination of the actions that should be undertaken in the communities; and a monitoring of activities and an evaluation of their results.

Survey Sites

Two local communities were selected for the study: Mokotow, a district of Warsaw with 400,000 inhabitants, and the Sianow commune of 12,000 inhabitants in Koszalin Province in northwest Poland.

Mokotow is the largest of Warsaw's districts. It is relatively young, having been incorporated as a city in 1916. Currently Mokotow is the fastest growing site in Warsaw and is highly differentiated from architectural, functional, and social points of view. Although mainly a residential area, particularly in the newly built parts of the district, Mokotow also houses many industrial plants, offices, and institutions, many of which have nationwide importance. Although Mokotow might be treated as a single administrative unit, social ties or a feeling of community identity may be observed at the level of one or several neighboring blocks of flats, or, at the most, a housing settlement, particularly in the newly built settlements, such as Ursynow.

The town and the commune of Sianow are located on the territory incorporated by Poland in 1945. The population stems almost exclusively from the postwar immigration from central Poland, but also includes individuals repatriated from the Soviet Union, Germany, and France. The commune is largely agricultural, and the town is fairly industrial. Koszalin Province was selected for the study mainly because it has been one of the larger alcohol-using communities for many years—a fact that may be related to the migrant character of the population.

Survey Results

The first stage of the study consisted of a pilot survey of 322 respondents who were interviewed (212 in Mokotow and 110 in Sianow). The questionnaire developed for the Community Response Study in Contra Costa County, California, was used. As a result of this pilot survey, a few questions, more useful for interviewing the Polish community, were introduced into the questionnaire.

The next step of the project consisted of interviewing people aged 18 or over in both communities, as well as workers with different agencies that deal with alcohol problems.

In Mokotow, 861 persons from the original sample of 1,000 were interviewed, while in Sianow, 499 out of 500 were interviewed. Drinkers are in the majority in both communities. The percentage of abstainers, or those who abstained during the 12 months preceding the interview, was 13 percent in Mokotow and 22 percent in Sianow. The average consumption in Sianow appeared to be 20 percent higher than in Mokotow. The beverage preferences also differed significantly, with imported spirits and grape wine in Mokotow replacing some of the vodka and fruit or homemade wine in Sianow. People in Sianow drink less frequently but consume more at one sitting.

Motives for drinking and abstaining did not differ very much between the two communities, although in Sianow the view that "drinking is a good way to celebrate" was more prevalent. Personal problems were more prevalent among male inhabitants of Sianow, whereas among women, where problems were much less prevalent than among men, problems were somewhat more frequent in Mokotow. The presence of illegal alcohol outlets was perceived to be the most important problem.

Agency interviews revealed that alcohol-related problems are perceived in both communities mostly in terms of alcoholism with some moralizing overtones, and that some respondents presented negative attitudes. Many interviewees favored the reintroduction of compulsory treatment for alcohol-dependent persons.

In the next phase of the project, we plan to present the surveys' results to the community. Then the authorities and voluntary agencies will be asked to formulate, on the basis of the presented data, their plans of actions.

Lessons From the Survey

The project is in a rather early stage of implementation, so our experience with community action is very limited. Therefore we will concentrate on lessons from the surveys.

During the pilot study in both communities, local interviewers were used and also interchanged between the communities. Differences in results were considerable, depending on which community the interviewer was from. More detailed analysis showed that in one community several interviewers were activists in the National Antialcoholic Committee, a voluntary organization dealing with prevention and education. These workers tried not only to get the opinions of the participants in the poll but at the same time influence their attitudes. This occurrence did not necessarily reflect a conscious effort on the part of the interviewers but, nevertheless, clearly biased the results. The special training for interviewers that followed the pilot study seemed to diminish this bias. However, this problem is inherent in action research where the role of the research team is not limited to neutral observation. The possibility of a conflict of values between the world of research and the world of action always exists.

Another problem that should be anticipated is the possibility of competitive attitudes between teams from two communities. The teams might feel that the results obtained by their community could influence their position and the esteem in which they are held by the authorities. Such attitudes could be dangerous during the evaluation phase of a project.

Another interesting issue arose when the visibility of the alcohol problems was investigated. Traditionally alcohol problems, along with housing problems, ranked very high in the opinion polls in Poland. Surveys concerning the prevalence of alcohol problems and interviews with workers of different agencies have confirmed the importance of alcohol issues. However, when an open-ended question is asked—What problems can be named that are a nuisance for your neighborhood or community?—the ranking is quite different (see Table 1).

This shift in priorities probably reflects several factors. First, the extended crisis situation probably heightens people's perceptions of such issues as supply of goods and services, difficulties with transportation, deterioration of the environment, and so on. Problems with alcohol thus become less salient. Second, the ranking depends on the manner in which the question is asked. When a close-ended question is asked, alcohol abuse and use is much more frequently named as a problem—because alcohol is perceived not only as a physiological, psychological, or social issue but also as a moral one, and omission of alcohol from such a listing could have not only descriptive but also moral meaning: not confirming the status of alcohol as an important problem could be seen as an indicator of the respondent's own moral sensibility.

Those who view alcohol and related problems from a moral standpoint tend to emphasize the significance of such problems no matter how prevalent the problems may or may not be. To illustrate this statement, it is worth recalling an informal talk between a Scottish doctor who coordinates a WHO project and a Polish primary health care doctor from a rural commune. Asked about alcohol-related problems in his catchment area inhabited by 10,000 people, the Polish doctor described alcoholism as a very serious problem, stating that there were five foci of alcoholism. In the course of further conversation, it appeared that according to his experience only five alcoholic families in his huge catchment area constituted that serious problem. Concentrating on such a definition of alcoholism, the doctor totally neglected other problems related to alcohol.

In this project, we are approaching the stage of defining the type of action to be undertaken in the communities. However, new factors, likely to influence the course of the project, have recently arisen. In the beginning of 1989 roundtable talks between the Government and the opposition were held in Poland. As a result of these talks, a consensus to reform the Government of the country was reached, and elections were held on June 4, 1989. This unanticipated election meant that the campaigns would coincide with the anticipated public discussion on the community response project. The research team felt that alcohol problems would lose their visibility next to such a big political issue as the electoral campaign. Therefore, the beginning of the debate about the project was postponed until September 1989 after the elections.

Table 1. Ranking of problems as perceived in Mokotow and Slanow

Type of problem	Proportion of respondents who pointed to the given problems (number of people who pointed to at least one problem = 100%)	
	Mokotow	**Slanow**
Shortage of goods and services (lack of shops, poor supply, etc.)	54%	30%
Disorganization of environment (disorder, scarcity of green areas, perpetual digging, prolonged building construction)	19%	4%
Environment dangerous for health (pollution, bad water, noise)	19%	3%
Problems with public transportation	17%	18%
Problems with technical infrastructure (breakdowns of elevators, water supply, other technical damages)	13%	13%
Lack of entertainment facilities (shortage of cafe-bars, clubs, recreational grounds)	11%	17%
Alcohol-related problems (public drunkenness, drunken brawls, ubiquity of alcohol)	10%	6%
Poor network of educational institutions	6%	4%
Bad human relations	5%	3%
Low accessibility of health services	1%	1%

Issues in the Development and Process of Community-Based Alcohol and Drug Prevention: The Midwestern Prevention Project (MPP)

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The Midwestern Prevention Project (MPP) is an experimental and quasi-experimental trial for the prevention of gateway drug (tobacco, alcohol, marijuana) and other drug use by adolescent youth, their parents, and community residents in the Midwestern communities that comprise the Kansas City and Indianapolis Standard Metropolitan Statistical Areas (SMSAs: approximately 2.7 million residents and 26 school districts/communities).

The overall objective of the trial is to evaluate the cumulative effects of five program components that represent counteractive strategies to community influences on youthful drug use beyond the effects obtained previously from school programs alone. These components include school, parents and family, community organization, health policy change, and mass media programs. The first four are introduced into communities at the rate of approximately one per year in an order that reflects proximal to distal community influences on youthful drug use (school and peers first, then parents and family, community organization, and health policy change). The last component, mass media, is used throughout all years to cover and support the other components and is broadcast over both intervention and control communities.

Schools and communities are assigned to program conditions on the basis of scheduling flexibility and demographic matching where possible (the Kansas City quasi-experimental design) or random selection (the Indianapolis experimental design) to intervention or delayed intervention control conditions. The research design is a 2 x 2 factorial, varying grade of program initiation (sixth or seventh grade depending on which represents the transition grade to middle or junior high school) by intervention (program or delayed program control). The measurement design is a 3-year lagged cohort-sequential design, with successive cohorts of sixth and seventh grade students participating in the program and assessment in Kansas City from 1984 to 1990 and in Indianapolis from 1987 to 1993.

Over 32,500 youth are evaluated annually with a self-report survey and a biochemical measure of smoking. Surveys are also administered to approximately 150 community leaders and 7,200 parents. The use of panel, cross-sectional cohort, and sequential (random weekly) samples enables multiple tests of program effects on a cohort of youth who receive all components versus those who receive mass media plus the usual health education classes alone, and subsequent cohorts of youth who receive some components versus those who receive single components of the program.

Five types of data are collected in the MPP that relate either directly or indirectly to program process, implementation, and outcome. Generally positive effects on mediators and drug use behaviors have been reported elsewhere and are based on self-reports, reports by others, and a biochemical measure (e.g., Dwyer et al. 1989; MacKinnon et al. 1988; Pentz 1986; Pentz et al. 1986, 1989a, 1989b; Rohrbach 1986).

MPP Development Issues

Three models were used to develop the MPP as a multicommunity drug prevention project that would represent the joint efforts of community planners and researchers. The models were matched funding, program implementation, and community organization.

Matched Funding

One very visible indicator of a community's commitment to change is procurement of funding for an intervention aimed at producing the change. The commitment may be heightened if funding is shared by participants in the intervention. The MPP uses a matched-funding model (1) to increase the ecological validity of the community-based drug prevention program and (2) because of limitations in Federal research agency budgets for funding a single drug prevention project expected to affect approximately 2.7 million community residents, of which 7 to 10 percent are target-age adolescents. For Kansas City, the link between the University of Southern California (USC) and the local funding agencies was initiated by Ewing M. Kauffman, founder and chairman of the board of Marion Laboratories, Inc. The time between first contact and baseline assessment of drug use in Kansas City—the initiation of the research component of the MPP—was approximately 4 months, because of Mr. Kauffman's initiative to begin programming as early as possible. For Indianapolis, the link was initiated by USC investigators. The time between first contact with the Lilly Corporation through the Lilly Endowment and subsequent baseline assessment was 2.5 years. The differences in the time required to mount the project in each site may reflect the relatively greater ease with which community entry is made if the community initiates a drug prevention program.

A major issue anticipated and addressed through application of the matched-funding model was how to promote visible, active community support for research as an expected part of a community drug prevention program. Research is used to feed back program results and recommendations to the project communities for annual program planning, implementation, and revision. Thus, community support for the program is inextricably linked to support for research. An additional issue was how to gain community commitment to a longitudinal, cumulative sequence of programming and research rather than to a short-term mass campaign for drug abuse prevention.

In Kansas City, researchers and Project STAR (Students Taught Awareness and Resistance) planners presented a three-point rationale to the community:

- Simultaneous implementation of all program components to all communities would dilute the time and resources available to monitor the quality of program implementation (Pentz 1986).
- Initial implementation with one-half the schools and communities would enable refinement of the program for better implementation with the remaining half, as well as providing a "wait-list," or delayed, implementation control for research purposes.
- Sequenced implementation of each program component would provide an opportunity to evaluate the relative effectiveness of different components.

Program Implementation

Several theories were integrated to develop a model for MPP implementation, including social learning and problem behavior theories of individual behavior change, transactional and system theories of person x situation x environment interactions in community change, and communication theories pertaining to the selective use of channels for program delivery and diffusion (Pentz 1986). A major issue addressed through application of the program implementation model has been how to maintain community reinforcement for program participation and quality of program implementation.

In each site mass media coverage, banquets, awards, receptions, and material goods (e.g., logo t-shirts and pens, baseball tickets) are used to reinforce both implementors and program recipients for participation. Quality of program implementation is enhanced by the use of these reinforcements with program implementors, by peer nomination of master trainers (e.g., teachers and parents) who facilitate the training of new implementors each year, as well as by staff observation and discussion of program techniques.

Community Organization

To translate funding and program implementation models into action in the MPP, a community organization model is applied that provides MPP project staff and community leaders with a series of sequential tasks, and evaluates the extent to which each task is completed before the next is initiated. The model incorporates the specific education, business, mass media, health agency, and government resources at each project site that are likely to facilitate change in community drug use attitudes and behaviors.

In Kansas City, community organization was initiated through private efforts, Marion Laboratories, and the Kauffman Foundation. Mr. Kauffman was associated with several large-scale civic service and health projects for the Kansas City metropolitan area before the initiation of the MPP. In combination with the executive director of Project STAR, these resources represented education, business, and mass communications interests, consolidated under Mr. Kauffman's central leadership.

In Indianapolis, various branches of the Lilly Endowment, Inc., rather than a single individual, had been associated with civic service, educational, and health projects in the Marion County area. In combination with the executive director of Project I-STAR (Indiana Students Taught Awareness and Resistance), the Lilly Endowment and I-STAR board resources represented educational, business, and mass communications interests consolidated under the board leadership.

The Kansas City model of community organization (i.e., a central corporate sponsor) has resulted in more singular control by Mr. Kauffman over the direction and community support for the project compared with Indianapolis. In contrast to Kansas City, the Indianapolis model of community organization (i.e., a governing board of 11 public school superintendents and 4 advisory councils that make recommendations to the board on program development issues) requires more shared decisionmaking. Each model of community organization has potential advantages and disadvantages. For example, while it may be easier to make major decisions more quickly under the Kansas City model, the Indianapolis model may facilitate community ownership of the project more easily than a model initiated by one individual or one company.

MPP Process Issues

Funding

Major funding issues in the MPP have dealt with how to manage three separate budgets (National Institute on Drug Abuse (NIDA), Lilly Endowment, Kauffman Foundation/Marion Laboratories) that operate on different calendar years, and how to modify budget line items to accommodate program changes that may occur within a given budget year. The first issue has been addressed by mutual negotiation for deferred or accumulated billing periods. The second issue has been addressed through a series of steps that include internal USC approval for grants and subcontract line item amounts; board or foundation approval at each site; and NIDA approval if major budgetary changes are proposed. Thus far, these broad budget management issues have been addressed in response to at least three specific changes in the MPP, including Federal research agency budget cuts, extended program development and refinement, and separate budgeting for paid mass media programming.

Research

Several specific research issues have been addressed in the MPP in response to community requests for slight changes in research or measurement design that would increase the ecological validity of the program and the research. These changes include the use of a quasi-experimental design rather than a randomized control design in Kansas City, whereby schools were assigned to immediate or delayed program conditions based on administrator flexibility to reschedule existing programming for the school year, with schools demographically matched within school districts where possible, to accommodate a project start date of 1984 that was 1 year earlier than NIDA funding.

In addition the length of the questionnaires was reduced, and new questions designed to reduce test fatigue and address new issues were introduced. In Indianapolis, where a fully randomized design was used, the MPP Advisory Board recommended that the parent program component be introduced a year earlier to coincide with the introduction of the student program. Because of the potential difficulty in managing the training and implementation tasks for the student and parent programs simultaneously, a compromise was proposed by Project I-STAR. The compromise was that the parent program component would be implemented across all schools in Year 2 of the project rather than in half of the schools in Year 2 and half in Year 3 as indicated in the original design. This decision may have helped alleviate some of the disappointment felt by control schools regarding the 1-year delay in receiving the school program component. Under the compromise plan, they received the parent program component along with the program schools in fall 1988.

Program

Several specific program issues also have been addressed in the MPP in response to community differences and community requests. These issues include the integration or reconciliation of the MPP program components with other materials or programs to which communities have been exposed; program revision and refinement; and proactive solicitation of community ideas and requests.

Project STAR has responded to ongoing community needs for addressing new programs and program requests without jeopardizing the MPP theory or design. For example, during the first year of Project STAR the American Cancer Society launched a smokeless tobacco campaign. Rather than trying to compete with that campaign, the Project STAR staff initiated cooperative discussions with the American Cancer Society to explore whether the society's materials were compatible with, or could be incorporated into, Project STAR. When Project STAR staff was informed that the goal of the American Cancer Society campaign was to teach adolescents about the negative effects of using smokeless tobacco, the Project STAR staff suggested that information about the social consequences of using smokeless tobacco be incorporated into the Project STAR curriculum lessons. This suggestion provided the American Cancer Society with a desirable forum for its information campaign and enabled Project STAR to expand its focus to address a community need without compromising the research efforts in Kansas City.

In terms of program revision and refinement, Indianapolis has the advantage of being able to draw on the Kansas City experience. For example, based on the evaluation of the STAR parent program training and implementation initiated in 1986, the Project I-STAR staff revised the parent program in 1988 to include a pretraining orientation session (in addition to training) for the principal, a supportive staff member, and a parent representative from each participating school. The original Kansas City protocol had recommended that each principal select and prepare parent committee members for their respective roles before training. However, in process and implementation evaluations, committee members reported that they had not been adequately prepared by their principals before training.

Project I-STAR staff, in consultation with Project STAR staff, believed that an orientation session might serve to better inform the principals, school staff members, and key parents about the significance of the parent program component, and thus encourage their full support and participation. In addition, the orientation was designed to introduce the variety of prevention activities that each committee could sponsor, and to illustrate different levels of involvement available to parents through Project I-STAR. Evaluation of the subsequent orientation sessions indicated that 84 percent of the participants found the sessions to be very effective in preparing them for committee roles, a substantial increase over the percentage reported in Kansas City.

In Indianapolis, the escalation of the community organization component from Year 3 to Year 2 is an example of how the project has attempted to anticipate community needs, as well as respond to them. Since the project was initiated, public awareness and concern about alcohol and other drug abuse has increased, as has the number of organizations attempting to launch drug-prevention programs and activities. In addition, an infusion of Federal monies has come into the schools as part of the Drug-Free Schools and Communities Act of 1986. These events presented an opportunity for Project I-STAR to take a leadership role in bridging the gap between the school districts and the other sectors of the community in promoting drug prevention.

Also, Project I-STAR cohosted the second National Prevention Network (NPN) research conference in Indianapolis. (The first NPN research conference was cohosted by Project STAR in Kansas City.) NPN is an affiliate organization of the National Association of State Alcohol and Drug Abuse Directors, and its purpose is to promote links among researchers and practitioners in the prevention field from each of the States.

Conclusions

Large-scale, longitudinal drug prevention projects require that researchers and community programmers be flexible about research and measurement design, development, refinement, and analysis of results. Ideally, any changes should be considered in light of enhancing the ecological validity of the program, and thus increasing the probability that the program will have a maximum and sustained impact on the community. The most mutually acceptable changes are likely to be those that have been negotiated by both researchers and community programmers. However, negotiation implies that each party is prepared to give up some control over the project and to devote more time to considering program and research changes than might be expected from single-party decisionmaking.

Historically, the potential for loss of control has been more problematic for researchers, whose funds and hypotheses are typically contingent upon the assumption of experimental control. Experiences with the MPP suggest that, thus far, mutual flexibility and negotiation have enhanced the ecological validity of the program and have not jeopardized the quality of the research. What is not known is the extent to which experiences of the MPP and any changes made to enhance the ecological validity of the program are generalizable to other communities. To a limited extent, we will be evaluating program process, implementation, and change in schools throughout Kansas and Missouri that have recently adopted the school program component of the MPP. Results of program diffusion throughout these two States are expected to be available within the next 2 years.

The process and outcome of issues encountered thus far in the MPP suggest the following directions for community action research in the area of drug prevention:

- Assessment of the limits of flexibility (i.e., community and research confidence limits in designing and scheduling intervention and measurement).
- Interim evaluation of the effects of annual feedback of program results to the community.
- Formative and summative evaluation of refined or revised program components compared with static program components that are not tailored to changes in the community.
- Evaluation of the impact of consolidated community prevention efforts on subsequent interorganizational networking for prevention and treatment services.

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A System of Early Detection and Prevention of Alcohol and Drug Dependence in Secondary Schools in the U.S.S.R.

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The need to prevent alcohol and other drug use by students in secondary schools has become critical. The objective of this study was to develop a prevention program based on accurate data that reflected the extent to which alcohol and other drug use have spread in the community. Input from specialists from various ministries and organizations were coordinated for this study. The basis for the information was anonymous surveys in six technical schools in one large industrial city. A total of 1,500 students were surveyed.

In the first stage of our work, methods to assess the extent of alcohol and other drug use at the schools were developed. Data provided via questionnaire responses by parents, teachers, social workers, the military, and students themselves were used for this assessment. The questionnaire was divided into four sections: demographic and social factors; frequency and quantity of alcohol use; type and prevalence of any other drug use; and attitudes toward psychotropic alcohol and other drug use of students, parents, and friends.

The data indicated that 70.4 percent of the technical school students use alcohol. Of these students, 83.8 percent use alcohol only on holidays, 8.2 percent use alcohol at least once a month but less than once a week, and 8 percent use alcohol at least once a week.

Technical school students typically begin using alcohol at 14 to 15 years of age and prefer low-alcoholic drinks. The most popular reasons given for using alcohol are "drinking in company" and "high spirits." These motives reflect the stereotypes for drinking alcohol that adolescents believe are characteristic of adults, as well as the tendency to achieve the euphoria that alcohol produces.

Ten percent of the adolescents have used drugs at least once in their lives. Most tried drugs for the first time in the company of others. A further 26.6 percent first tried drugs alone. In addition only half of those who indicated that they had used drugs once restricted themselves to that one attempt, and 20 percent of adolescents who had used drugs had tried psychotropic substances more than 10 times. As a rule, the respondents reported pleasure as a result of using these substances. In the educational institutions studied, students suggested that they preferred using drugs either by inhalation or injection.

This information made it possible for us to develop a system of prevention appropriate for all the schools. The prevention program had two main thrusts: one for the whole school (course) and one for individual students.

The measures for the whole school included providing adequate information to teachers through specially prepared courses on the extent of the use of psychotropic substances by students and the problems of preventing such use, and providing medical information to parents. Students were dealt with both in groups and individually.

The work with students was carried out in collaboration with teachers, medical personnel, law enforcement agencies, and parents. The work began with identifying students inclined to use psychotropic substances. The students from the "high-risk environment" group underwent obligatory examination by an addiction specialist. In the case of alcohol and other drug dependence, the student was provided with medical treatment. Adolescents whom the specialist did not consider prime candidates for special treatment were individually supervised by teachers.

The effectiveness of the program was assessed based on the following criteria:

- The comparison of the number of newly identified students using psychotropic substances versus the numbers who had stopped using psychotropic substances.
- The proportion of students detected by teachers and parents, and the proportion of students detected and registered by law enforcement agencies.
- The number of students repeatedly arrested by police for appearing intoxicated in public places.

The introduction of the prevention program in the educational institutions appears to have stabilized the number of adolescents using psychotropic substances.

In the course of our study, we came across a number of problems that complicated the work with adolescents using alcohol and other drugs. First, the number of students who use alcohol and other drugs is growing. Several decades ago they were considered to be deviant, as having psychic disorders and belonging to antisocial groups. Their behavior is no longer considered antisocial. Also, the number of drugs used in addition to the "classical" narcotics and widely used psychotropic preparations is growing. These factors increase the difficulty in fighting the spread of drugs.

Despite active prevention programs, the amount of information about alcohol and other drugs that gets to parents and teachers is very low. Their knowledge about the effects of alcohol and other drugs is quite inadequate. This situation makes it impossible for them to detect at early stages all the cases of psychotropic drug use by students.

Collaboration between various ministries and authorities, educational institutions, health services and law enforcement agencies, and social organizations is minimal, and coordination of activities is rather poor because specialists consider this problem to be purely medical.

A number of problems make it difficult to detect students using alcohol and other drugs. First, teachers often try to conceal the fact of alcohol and other drug use by their students to create the impression that they are doing a good job. In addition, the educational institution sometimes tries to get rid of those students using alcohol and other drugs, forcing the students into antisocial groups or resulting in social isolation. A great number of parents are afraid of action being taken against their children and do not inform doctors and teachers about their children's alcohol and other drug use.

A double standard exists among middle-aged people in their attitude toward alcohol and other drugs. While they consider drug abuse inappropriate, an attitude that makes them easily recruited as collaborators in prevention work, at the same time they accept the abuse and use of alcohol on holidays, even by adolescents 14 to 16 years of age. A concept we use in our work is that experimentation with alcohol (as a gateway drug) by children very often leads to experimentation with other drugs, which is why alcohol use should be eliminated.

The important trend in prevention should be the creation of psychological services in all educational institutions. These services would help both students and their parents. Anonymous forms of medical help and early identification should be prevalent. An educational campaign that attempts to rehabilitate and reintegrate alcohol and other drug abusers and users into society, without turning them into social outcasts, should be the ideal. The creation of alternative alcohol and other drug use, but without punishment, should be the basis of the work of various agencies, with an emphasis placed on the advantages of a healthy way of life.

Summary

The article contains the results of the survey on 1,500 students of technical schools. Results have been obtained on the prevalence of consumption of alcohol and other drugs. We have singled out the factors affecting the initiation of various drug taking by students. A program is proposed for prevention of alcohol and other drug consumption by students. Criteria of effectiveness evaluation of prevention actions have been developed.

Experiences With Israel's Kibbutzim Project for Preventing Excessive Drinking

Shoshana Weiss

The kibbutzim, which represent 4 percent of the total population of Israel, are voluntarily closed societies based on communal property, production, and labor, and on communal consumption and living arrangements. The kibbutzim play an important role in Israel's security and economy (agriculture and industry). There life relies on the principle of "from each according to his ability, to each according to his needs" (within the economic possibilities of the commune). The development of intellect, personality, and character, and of the continuity of kibbutz values of labor, equality, collectivism, democracy, voluntarism, and mutual aid are inseparable in the kibbutz school.

Need for Prevention

Surveys conducted by kibbutz educators in recent years and a study by a kibbutz researcher of youngsters in the kibbutzim (Natan 1986) suggest that the problem of youth drinking, even within this context, has worsened. Clearly something has happened to the social environment in the kibbutzim and some environmental factors have been altered and have placed individuals at increased risk.

The kibbutzim, as small groups, are subject to the influences of their surroundings. In recent years, with increased affluence, improved quality of life, industrialization, and efforts to be "like all societies," the movement in the general Israeli society has been away from moderation and the negative assessment of excessive drinking to social and routine group and individual drinking. Contact with tourists and volunteers and their foreign norms of drinking, visits to foreign countries, and the influence of imported television programs have contributed to the growth of nonritual[1] alcohol drinking as a tool for emphasizing self-oriented values, fun, and pleasure. Kibbutzim youngsters, exposed to outside influence from television, press, military service, and contact with non-kibbutzim youth, have started drinking beer like their urban peers. Moreover, alcoholics from kibbutzim have started to present for treatment in percentages similar to those in the general population.[2] These factors led to the development of the kibbutzim prevention project.

Some researchers believe that the home is the first arena to prevent alcohol abuse; others believe it is the school. The kibbutz school actually is home. Most kibbutzim have their own schools, or there is a school for several small kibbutzim. In some kibbutzim children sleep together separated from their parents. Thus excessive drinking by the individual in the kibbutz influences the rest of the peer group more so than elsewhere. Furthermore, the individual's problems affect the whole closed society of the kibbutz and not only the family.

To address the increased alcohol problems, the Kibbutz Movement named a task force in 1986. Its goal was to encourage the establishment of educational prevention programs in schools. Some schools started making efforts on their own but their local programs did not include strategies that emphasize interdisciplinary information, strengthen personality attributes such as decision-making or refusal skills and modify the environmental factors that place individuals at risk. Various schools in the kibbutzim decided to adopt the national curriculum, "Alcohol and Drunkenness" (Moore and Weiss 1985; Weiss and Moore 1986), published in 1984 for urban secondary schools. However, the curriculum had to be revised to address kibbutz youngsters in the context of their special environment.

Teachers changed many components in the educational program on their own, each school used different exercises and subjects, and teachers from the kibbutzim were encouraged to attend training sessions. By the end of 1986 the national curriculum was modified for the kibbutzim context by incorporating changes based on teachers' experiences with the urban version, and the evaluation sheets and feedback from schools in several kibbutzim. Because students congregate for lengthy periods at kibbutzim schools and are essentially a captive audience, the schools can be important in a communitywide approach. The new "Kibbutz Educational Version" curriculum was to become the center of a community action effort, aimed particularly at young people but taking into account parents and the rest of the kibbutz members. Changing local drinking regulations was also to be included.

The Kibbutz-Community Model seeks to ensure that everyone who plays a role in the students' lives is provided the same information as the students and is involved, making the total community supportive of the program. Further details of the educational program are available elsewhere (Weiss 1988).

Selected Issues in Adapting the Urban Curriculum for the Kibbutzim Project

In urban schools, alcohol abuse prevention activities generally stem from instructions of the Ministry of Education and Culture. In the kibbutzim, the community itself recognized the urgency of marshaling community action for prevention.

While the urban version of the curriculum focused on the relationship between personality variables and alcohol abuse, the new version focused on the interaction of community conditions as risk factors for alcohol use. There is interest in the kibbutz (participating in the project) in altering environmental risks by changing local drinking ordinances to restrict drinking at public events.

For example, beer is no longer allowed at young people's clubs. The sale of alcohol to families has been reduced, and only ritual drinking is permitted on Friday evenings in the kibbutz dining room and on holidays, including Purim (when Jews are permitted to get drunk).

Kibbutz life emphasizes specific values that required modification of the curriculum. The objective to change attitudes and ensure only moderate drinking in accordance with the normative orientation toward drinking embedded in the Jewish culture (and not to achieve "dryness") has been enlarged. The need to return to kibbutz values as one of the reactions to excessive drinking has been emphasized. In addition, many issues have been eliminated from the "Urban-Version" and the educational program has been changed from biologically oriented to a social science-oriented program.

Only 8 instructional hours are mandatory for the program in urban schools annually. This limited time is insufficient to develop the community process, so the kibbutz version involves almost 30 hours. This modification is possible because the kibbutz is a community in which school is home and also because the kibbutz can afford facilities that an urban school cannot. The core of the project is a 2-day workshop that is supplemented with summary, reinforcement, and extracurricular activities.

The urban curriculum was adapted to the kibbutz context by the addition of exercises concerning decisionmaking and values clarification related to kibbutz life. Two additional topics of discussion were peer group pressure among kibbutz youth and alternatives to drinking at leisure time. The students also met with an alcoholic from the Kibbutz Movement.

Issues Confronted During the Project

Several issues were encountered during implementation of the project that necessitated further modification of the program. The first problem concerned evaluation. Kibbutz educators did not use the questionnaire that had been developed previously to measure attitudes, but instead preferred to use their own. Because their primary concern was with the acceptance of the program by the students, educators questioned the students regarding their attitudes toward the various components of the program. If the program effectively contributed to their knowledge, understanding, values, skills, and sociability, the program was considered a success. Teachers changed certain items or components of the project based on students' responses.

A community action prevention project should, if possible, be implemented where the chance of success is greatest. In this project the greatest chance for success appears to rest with the kibbutzim that had implemented prevention efforts in past years, that recognized primary prevention as a key factor, and that have stronger and more solid ideological attitudes. But the kibbutzim that participated in the project were not those at all. The kibbutzim with more serious drinking problems joined later. They saw the other kibbutzim doing prevention and curtailing the socioenvironmental forces that encouraged widespread availability of alcohol. Contrary to expectations, once awareness of what was occurring in similar communities grew, and it was recognized that implementation of a prevention project need not hurt the reputation of a kibbutz, other kibbutzim expressed interest in the project.

In addition to the need to change the structure, the materials, and the content of the urban curriculum, several values peculiar to the kibbutzim presented some difficulties to the program developers. For example, in the urban version, the issue of personal responsibility is addressed by suggesting that a mature person is responsible not only for himself but for others as well. Therefore, trying to prevent a person from drinking too much is viewed as responsible behavior. However, such intervention is problematic in the kibbutz.

The dichotomy between two fundamentally different types of values—the right of the collective (to defend its members from damage) and the right of the individual (to do as one likes in one's room)—concerning alcohol use is very sensitive because little privacy is available in the kibbutz. This problem was solved by an alcoholic from a kibbutz who published his personal story in the kibbutzim newspaper. In the story the man told everybody that he was lucky he had friends who had intervened in his private alcohol drinking—a comment that served to legitimize interpersonal intervention. His article influenced the kibbutz students and was included in the curriculum materials.

Conclusion

In Israel we have learned that educational and personal involvement approaches to prevention are insufficient. We are just now beginning to understand the importance of modifying social and environmental factors through community action programs based on educational programs in schools. Within a few years we hope to have more evidence about the effectiveness of such approaches. This first community action project addressing a special community in Israel—the kibbutzim—may serve as a model in the design and application of future projects within various groups in our society (Arab communities, religious Jewish communities, low-status communities, and such). While the kibbutz differs markedly from larger Israeli society, applications from this project may still have relevance. Moreover, there is a need to operate on a national level and to influence the media in order to build a more convenient and supporting climate for community action projects in all Israeli communities

Notes

1. Judaism is permissive in matters concerning alcohol use and its ritual consumption is encouraged. Many Israelis consume sacramental wine during

the Sabbath. Therefore, it is important to distinguish between alcohol drinking in connection with the Sabbath and drinking outside these occasions.

2. Since the kibbutzim always try to solve problems on their own, even this figure might underestimate the problem.

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A Health Education Intervention Program in a New Delhi Community: An Evaluated Study

Davinder Mohan and Hari Kesh Sharma

This study was shaped by the requirements of the funding agency and the needs of health professionals involved from the collaborating centers. The investigators were interested in exploring the possible links between tobacco and alcohol consumption and subsequent abuse and use of other drugs. The requirements of the Indian Council of Medical Research (ICMR) reflected changing policy perspectives of the Government of India, specifically, that all research must have built-in action and evaluative components to facilitate the use of such research in ongoing health programs. In addition, the working group on Drug and Alcohol Dependence, convened by the council, tended to support such empirical activities for subsequent 5-year plans and funding. Finally, the All-Indian Institute of Medical Sciences (AIIMS) center was eager to ensure continuity and maintain its program of previously funded research activities with a team of researchers who had been involved in the field of drug dependence since 1976.

The goals of the study, which initially was multicentered (New Delhi, Dibrugarh, Bangalore, and Ranchi), were as follows:

- To study the existing illicit patterns of drug abuse and use in different regions of the country.
- To study the existing knowledge of reasons for such abuse and use, including knowledge of possible adverse health consequences.
- To identify and study the patterns of tobacco and alcohol abuse and use among the respondents in the above samples.
- To study the impact of health education materials on the existing patterns of tobacco and alcohol abuse and use.

A number of specific hypotheses were thus formulated:

- The intervention program would lead to reduced incidence and prevalence of tobacco and alcohol abuse and use.
- The intervention program would have greater impact on sociorecreational users of tobacco and/or alcohol.
- The substitution of drugs would not occur in persons who stopped alcohol and/or tobacco abuse and use.

- The future of users of other drugs (e.g., users of heroin, cannabis compounds, and such) would come from existing tobacco and alcohol abusers and users.

The details of the study, including a discussion of outcome, have been reported elsewhere (Mohan and Sharma 1987).

Description of Study Areas and the Samples

A cluster of 1,000 urban slum dwellers and a separate cluster of 1,000 industrial workers in a medium-size industry were selected as subjects for the project. The slum colony had some of the features of urban ghettos found in the West, but differed in other dimensions. Most of the slum inhabitants were migrants from rural areas. The majority of them were engaged in manual or semiskilled jobs. The jobs were not regular and often the household would run on the basis of daily earnings. Women also worked full- or part-time and contributed substantially to household income. The housing arrangements were single units with overcrowded spaces, and community members as a whole shared limited common civic amenities. A comparable control group was also selected.

The cluster of 1,000 workers came from a medium-scale engineering unit and constituted a second control group.

The two study groups had certain common features. The inhabitants of both the slum areas and the industrial workers had a common rural background and had recently moved to the urban areas. They retained a strong affinity to their rural places of origin and subscribed to traditional values. However, they were not prudent spenders or good savers. They imitated the lifestyles of the neighboring urban groups by purchasing consumer goods, including alcohol and tobacco, that symbolized urban lifestyles.

Early in the project, we realized that an indepth study of the existing social organization patterns in the population would be necessary. Therefore, the existing formal and informal communication channels, the local influential group leaders, and the local power hierarchies were studied. This study indicated that the urban slum residents did not constitute a homogeneous group. These individuals consisted of subgroups affiliated to their caste, language, and place of origin (e.g., migrants from other Federal states). These subgroups had their own beliefs, customs, and lifestyles. At least once a year, they would visit their place of origin, carrying the latest news back and forth. These extended kinship ties exerted pressure on the members to conform to traditional values. The value and belief systems also influenced whether subgroup members adopted or rejected new programs or services offered by either governmental or nongovernmental organizations. These results were used later to promote behavior changes in the desired direction by taking the time and effort to explain the aims of the program to the communities. This effort was rewarded by enhanced community participation; however, repeated efforts were needed to maintain links within the community.

In the industrial setting, a clear dichotomy of cliques was evident, with unskilled or semiskilled workers constituting one group and managerial and technical staff constituting a second. Informal group affiliations and channels of decision making proved to be more powerful than formal channels of communication and were thus a central component in disseminating program information. However, the formal consent of the workers' union and the management was obtained before starting the project. The consent of the workers' union played a pivotal role in the participation of the respondents.

Development of Health Education Material

At the initiation of the project, appropriate health education materials were assumed to be available through governmental and nongovernmental agencies in the health care sectors. However, no evaluated materials were available, and the coordinating center was assigned the task of developing appropriate materials. Though exciting, this task took considerable time and energy. Another constraint in the development of material was the lack of clarity on the part of both the funding agency and the experts as to the content of the health and other messages, which resulted in different types of health education material being tried and discarded after pretesting. The final choice for the program was a synchronized, slide-tape production with commentary and background music. Respondents would receive more than one exposure to the program, and no other concomitant or subsequent intervention would be undertaken. In the experimental groups, after the immediate impact evaluation, about 12 months elapsed between exposure to the program and the evaluation.

Initially the messages in the slide-tape series were based on knowledge and attitudes toward alcohol and tobacco consumption; however, some experts thought that more relevant messages should be included. Ultimately the series may have been overloaded with messages, since the evaluation suggested that the messages introduced by the experts were not remembered by the target group.

The evaluation of the health education materials also determined that the respondents wanted to know what they could do to avoid or minimize the adverse health consequences and how to stop tobacco and alcohol abuse and use. The project team quickly developed a second set of materials that addressed these issues. Once again differences existed between what the experts thought should be the content and what the project team thought. A communication expert, however, facilitated this task and allowed both groups to arrive at consensus.

The final intervention materials were pretested in comparable areas to determine which of the several alternative versions of a communication would be most effective and to identify those elements of a single communication that could or should be altered to increase its impact. The pretesting exercises also provided information regarding the attractiveness of the visuals, comprehension of the messages, respondents' identification with the story line, and credibility of the messages. The pretesting exercises and the feedback received from the community at the different centers also contributed to the final intervention program.

Implementation at the Field Level

The implementation of the program was initiated with the formation of action committees in both the urban and industrial experimental groups. The Industrial Action Committee (IAC) comprised representatives from the managerial and technical staff, workers' union, company health personnel, and the respective departmental heads. A delicate balancing act was required here in that many individuals from the managerial cadres objected to being grouped with workers. The Urban Action Committee (UAC) consisted of 10 members, including teachers, local government officials, and influential individuals of the area along with 2 community participation promoters.

Exposure of the Material

The participants were formally invited to attend the slide-tape presentations in groups of 50. The IAC helped identify participants, introduce them to the program, and trace those who did not attend. In fact, 850 of the initial target group of 1,000 attended sessions. The majority of nonattenders had left the company or had been relocated. The presence of and cooperation of the workers' union representative contributed immensely to the program's success. Despite having to address problems such as electrical failures, the program was successful.

As noted, the slum community consisted of diverse subgroups, and despite the best efforts of the project team and the UAC team, this heterogeneity produced problems. Because the slums had no official status, any government-sponsored action was suspect. As was the case with other government programs, such as family planning, participants imputed ulterior motives to the project.

The UAC also presented difficulties. Unlike the IAC, these community subgroups had shown little evidence of cooperating over an extended period. The UAC team was also subject to various pressure groups, and, hence, the retention rate of participants was low. In the slums, other problems were also present. The presentations for these participants, the majority of whom were daily wage workers, had to be scheduled either on weekends or late in the evening, and women with small children had to be accommodated in the afternoons.

Attendance by those who were not a part of the study group but chose to see the slide-tape was difficult to control.

The small group discussion after the slide-tape presentation provided an additional opportunity for interaction. We believe that this exercise played a key role in clarifying individual misconceptions, and rectifying false beliefs and prejudices associated with alcohol and tobacco abuse and use in group situations. Questions on such topics as the government's policy of easy alcohol and tobacco availability originated primarily among the participants in the group discussions, and the presence of abstainers and women were helpful in questioning the high social status given to the use of alcohol and tobacco.

The Outcome

In all the groups, some participants (1 to 2 percent) on the spot, symbolically decided to immediately stop smoking tobacco and consuming alcohol by breaking cigarette/bidi[1] packets or taking a pledge in front of the group. Although these decisions were mostly emotional, the behavior changes persisted for varying times, and in some instances were sustained.

The impact of the program was greatest among those alcohol and tobacco abusers and users who were using these substances socially. Most of them were less than 25 years old and did not have a long history of consumption. Female social alcohol users became abstinent, and the behavior, as reflected in the repeat survey, was sustained.

Even though the messages on the adverse health consequences of tobacco and alcohol abuse and use (e.g., cardiovascular disease, cancer, and liver disorders) were retained maximally among the heavy alcohol and tobacco users, the sustained impact in this group was much less. Many people tried to stop using alcohol or tobacco but often experienced withdrawal symptoms because of the sudden cessation.

The program led to a small sustained community movement toward more awareness of alcohol and tobacco abuse and use and their adverse consequences. In the community the most unwilling participants in the early stage (women and male abstainers) became the core groups for maintaining the program. Another immediate impact of the intervention program in the slum areas was that participants discouraged alcohol consumption in public places (street corners, public parks), in front of children, and in serving guests. The adult participants questioned their own tobacco and alcohol abuse. The elders were also forced to think about their own behavior, especially when they became aware that children imitate adult behaviors. Hence, elders reduced the practice of asking their male children to procure tobacco and alcohol products locally for them. The immediate impact of the program on the group was also visible when the local vendors of cigarettes/bidi reported a decline in sales of tobacco products.

Problems Encountered

Various problems were encountered in conducting this project. For example, the funding agency, the top body for coordinating medical research in the country, has a comprehensive mandate. However, the agency was not familiar with this type of project and was not sensitive to the needs of the work group.

This lack of understanding was reflected in problems associated with meeting the statutory requirement of the funding agency that we involve consultants in the project. The consultants used had experience in epidemiological and clinical mental health research, but not in program intervention. This lack of experience with drug abuse research initially led to conceptual and pragmatic difficulties. The services of experts from the fields of health education and communications were also used in developing the package. This inappropriate matching of talents led to various interpersonal strains and contributed to a 2-year overall delay.

We believe that these difficulties may have contributed to the decision by the funding agency to restrict the impact evaluation study to New Delhi, thus compromising the useful information collected at the three regional centers during baseline survey and pretesting.

Additional problems revolved around the use of action teams that, whether in the industry setting or in the slums, had their limitations. Also, the project team had to consistently balance various external pressures, including political pressures, that became more marked as time passed. When the project was initiated, the general elections were just over, but toward the project's end the elections were again imminent, creating an uncertain political climate in which to conduct the project and plan for the future.

These problems have been outlined to help prospective researchers in developing countries prepare for problems they may face in initiating evaluations of drug abuse and use prevention strategies.

Notes

1. Bidi is made from unprocessed tobacco that is manually rolled in a dry leaf without any cigarette paper.

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Community Planning for the Prevention of Alcohol Problems: Treatment Services and Community Action Initiatives

Jonathan Chick

The experience described here, of research in the general medical setting, was designed to evaluate an early intervention strategy with excessive drinkers. The research occurred as part of a sequence of research that began in the 1970s and showed that smokers in general practice could be influenced by brief counseling. This study was followed by the use of blood test feedback with heavy-drinking Swedish men attending a health screening (Kristenson et al. 1983). Our project in a general hospital in Edinburgh found a significant result favoring a brief intervention over nonintervention among men admitted to medical wards who fulfilled a criterion at interview of being early problem drinkers or excessive drinkers (Chick et al. 1985).

Funding

Funding was readily available at the beginning stage of this study, which was a rigorous randomized controlled study with followup outcome data to be collected by a blind assessor and blood tests included as objective markers. Later funding proved far more difficult to obtain.

Setting Up the Project

We, the researchers, were clinicians. However, we were not clinicians from the same community (the general hospital) for which the intervention was designed. We chose to supply the intervention and the intervention-worker, thus keeping control. The worker was a middle-grade nurse with 1 year's experience in alcoholism treatment and an empathic, authoritative interviewing manner. She also collected the intake data, and logged all patients seen, as well as those meeting the study entry criteria. Thus, we maximized the success of the research at the expense of making future extrapolation to other settings less than certain, because some settings would have difficulty recruiting such a competent and committed worker.

We approached five services in the hospital. All senior nurses and all senior physicians but one agreed to follow the patients to be studied. We used personal contacts to achieve this high acceptance by the physicians, some of whom were skeptical about the project's usefulness. (They were more interested in our removing and curing the recalcitrant chronic alcoholics who moved in and out of their wards.)

Running the Project

In the men's wards, recruitment of problem drinkers using our screening methods was brisk. Unfortunately, this was not so in the women's wards, and the decision was made to restrict the study to men in order to keep within our budget.

Using the Results

A preliminary report at an international conference led to a spate of inquiries from far away, and to plans overseas and elsewhere in the United Kingdom to replicate the study or even implement it on a service basis. In the United Kingdom, the results were published in the widely read *British Medical Journal*. However, in our own city, the study has not yet led to the creation of a service post to do the job of our nurse in any of the hospitals. Admittedly, it has been a time of shrinking health service expenditure (in real terms). However, the local, rather than the ministerial, level is where we seem to find the most skepticism. We find that at this level there is less interest in the *p*-value of statistics used in our analysis of the difference in outcome between our controls and intervention groups and more interest in whether cash savings to the hospital can be shown to accrue if the program were introduced there. We should have understood this attitude at the outset. Now, another study is being planned to make available detailed costing of the project and its savings to the health authority.

The Malmö study in Sweden has maintained a longer followup and showed a reduction of mortality in the treated group. In our city, where services are readily available, keeping a nontreatment control group would have been difficult. But just as the costs of death to a health authority are hard to estimate, so also are the social costs of illness. Such social costs are highly important in alcohol problems. Our present Government has a strategy of honing services to their maximum cost-effectiveness and whether the social costs of illness will be considered needs to be seen. However, locally we are encouraging joint planning, whereby some health decisions are made by taking into account views of the social services and voluntary services. Such joint planning may help projects, such as the use of our early intervention nurse, gain a footing.

This study was a novel enterprise in a hospital setting. We hope that our experience holds promise for similar undertakings in other health care settings. However, we cannot assume that the program is necessarily generalizable. Furthermore, the importance of alcohol problems in medical settings is not widely acknowledged and practitioners may not feel that it is their role to counsel excessive drinkers or that they have the skills to intervene.

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CHAPTER 4

Extended Case Studies

Impediments to Changing Local Drinking Practices: Lessons From a Prevention Project

Norman Giesbrecht, Paula Pranovi, and Laura Wood

Introduction

This paper describes experiences with a community-based project to reduce alcohol consumption among heavy drinkers. The study was conceived as a test of the distribution-of-consumption model (Ledermann 1956, 1964); other factors, however, such as the choice of community for the intervention, the nature of available community resources, and the response of the community to the project appear to have been important influences on the outcomes of the study. Thus this discussion extends beyond an assessment of the appropriateness of the Ledermann model to an analysis of the factors that may have hindered or facilitated the actual implementation of the project.

Description of the Study

Design

The study was designed (Giesbrecht et al. 1981) as an assessment of the distribution-of-consumption model initially articulated by Ledermann (1956, 1964) and further developed by de Lint and Schmidt (1968), Bruun et al. (1975), Schmidt and Popham (1978), and Skog (1980). The key objective of the study was to determine whether a change in the proportion of heavy alcohol consumers has a measurable impact on the overall distribution of consumption. Secondary objectives were to assess the interaction between heavy and moderate drinkers and to assess the impact of a drinking management intervention on heavier consumers.

A multisite study was undertaken with an intervention community and two control communities. Community 3 was the "pure" control community.

Community 1 (the intervention community) and community 2 (the regular control community) were surveyed twice; the second survey (time 2) was done 24 months after time 1 (the baseline). During the interval between surveys, an 18-month, multifaceted alcohol reduction project was conducted in community 1. Funding levels made it impossible to survey the entire population, but concentrating on the adult males made it feasible to include a higher proportion of heavy drinkers in the sample. The intervention was offered to both males and females.

Community Selection

Three southern Ontario communities of 8,000 to 12,000 inhabitants were selected on the basis of their similarities in (1) patterns of alcohol sales by season, (2) stability of the rates of apparent consumption over several years, (3) services available for heavy drinkers, and (4) demographic characteristics.

Through consultation with regional staff of the Addiction Research Foundation (ARF), we focused on communities in which there were no extensive programs on alcohol issues. This effort was made because it might have been difficult to find three similar communities with active programs and because the introduction of a research-linked intervention where there were extensive services might confound the project and/or interfere with the services. Additional selection criteria specified that communities should—

1. have the population size necessary to facilitate prevention activities in the social and health areas but not be so large as to substantially increase the cost of the surveys;
2. show above-average rates of consumption and so be expected to have a substantial proportion of heavy consumers;
3. demonstrate relatively unchanging rates of alcohol sales over several years, indicative of stability in both the drinking culture and in economic and social conditions;
4. have experienced no recent dramatic changes in the size of the population or population characteristics so that the sample would remain representative;
5. be almost completely Anglophile to maximize homogeneity;
6. be self-contained (not satellite towns linked to near-by urban centers) and thus less likely to be contaminated by other cultural influences; and
7. have local leadership willing to participate in the study so as to facilitate the implementation of all aspects of the project.

Data Collection

Surveys. Surveys were conducted in midwinter 1984 and 1986, times when there were no special festivals or events associated with unusually high rates of consumption and when official statistics on alcohol sales suggested that monthly consumption was at or below the annual mean. The surveys were distributed door to door and then picked up 1 week later.

A census was used to increase the probability of having a population large enough to permit the measurement of changes in alcohol consumption, and to increase the size of the panel component—that is, representing individuals who participated in the surveys at both times—and thus the potential to analyze changes over time on a case-by-case basis. The number of respondents varied between communities and with time. The number of respondents, with the crude response rates, is shown in table 1.

Table 1. Number of respondents in the Ontario prevention study, with crude response rates*

Community and survey	Number of respondents	Crude response rate (percent)
Community 1 (intervention)		
Baseline survey	1,550	57.5
Second survey	1,220	45.0
Community 2 (control)		
Baseline survey	1,639	41.2
Second survey	1,702	42.0

*This proportion is not based on the number of males contacted but on the estimated total adult male population—using census data and extrapolation between census years, assuming that all were available in the town to be contacted during the survey periods.

The survey instrument assessed individual alcohol consumption by using various indicators of typical and heavy drinking, as well as attitudes toward alcohol use, prevention, and treatment. Topics addressed in the surveys included volume and frequency of alcohol use, the context of drinking and nature of drinking occasions, pressures to drink or curtail drinking, health and social consequences experienced in connection with alcohol use, attitudes and norms about drinking and alcohol-related behavior, and views on treatment and alcohol dependence. Demographic characteristics were also noted.

Aggregate statistics. Monthly aggregate statistics were obtained for up to 8 years on three groups of variables—alcohol sales, alcohol-related hospital statistics, and police statistics—as well as population data. Thus with three towns and as many as 96 data points per variable, a large data file was created for this aspect of the project.

Intervention and Documentation

The goal of the intervention was to reduce total alcohol consumption among heavy consumers in community 1. An educational and counseling program was offered to heavy consumers, who were recruited through medical and legal referrals, through advertisements, as well as through word of mouth. The counseling service was available to both men and women and (as space on the counselors' schedule permitted) to nonresidents of community 1. Behavioral change was also pursued indirectly through more general educational measures, influencing local alcohol policies, server intervention programs, and training workshops. These measures were pursued to create a supportive, positive social context for the efforts of individuals in the counseling program who were trying to reduce their alcohol consumption, and also to encourage others who were not in the program to curtail their consumption.

In addition, staff of the local project office joined a number of committees, some of which dealt with alcohol issues exclusively, as well as others in which alcohol use was considered in the context of health and social problems. Table 2 summarizes the type and number of activities that took place during the course of the intervention.

Table 2. Summary of intervention activities in the Ontario prevention study, September 1984 to March 1986

Type of activity	Number
Media ads, newspapers, mail-outs	77
Presentations and workshops	48
AECP*-sponsored committees: union, server, etc.	8
Meetings: health and social service committees, local professionals	69
Total	202

Source: Giesbrecht 1987.

*AECP = Alcohol Education and Counseling Program.

A small suite of offices in a multipurpose commercial building located at the center of town was used as the project office for both the counseling service and the other project activities. One to three resident staff members worked in the project office; the project director and one or two associates came from Toronto at least monthly to take part in local events and to collaborate in planning intervention activities.

The Alcohol Educational and Counseling Program (AECP) for heavy drinkers was based on findings in the behavior modification literature (e.g., Sanchez-Craig 1984; Marlatt 1982) and was developed through pilot projects involving more than 100 clients in three different settings. This program consisted of seven weekly one-on-one sessions of about 1.5 hours each. Whereas each session had a different theme, the structure of each meeting was similar. The counselor and the client together reviewed a drinking diary kept by the client and discussed the previous week's efforts to remain abstinent or to curtail drinking. After the client had viewed serialized video material developed for the intervention and had discussed it with the counselor, strategies were devised whereby the client could better control his or her alcohol consumption during the coming week.

During the first session, the client's recent drinking history and motivations for participating in counseling were reviewed. Instructions for accurately monitoring alcohol consumption were given. Subsequent sessions involved conducting an assessment of alcohol dependence and negotiating an achievable drinking level with the client, reviewing the client's pressures to drink and cues for heavy consumption, planning strategies to enable the client to achieve his or her goals, and discussing procedures for terminating relapse should there be a return to heavy alcohol use.

Client response to the program was documented through counselors' notes and data forms. In addition, client comments about drinking habits and the conventional methods of managing alcohol-related complications in their communities were recorded.

In conjunction with the intervention, the project staff also collected information about community perceptions of alcohol use and responses to alcohol problems. They did so by participating in community meetings concerning alcohol issues, by speaking both formally and informally with individuals or representatives of particular professional groups, and by observing the structure of the alcohol response network in the community.

Observations

Client Data

It appears that members of the client group reduced their consumption of alcohol during the course of their participation. The percentage of the client group drinking more than 14 drinks per week declined between the week before the program began and the last week for which data were available for each client (fig. 1). The median dropped from 20 to 9 drinks per week during this interval, and the mean from 15 to 7 drinks per week. If usual consumption had been selected as a baseline measure, the decline in the mean consumption would have been even steeper. A number of clients had reduced their consumption and some had stopped completely in the week or weeks before joining the program; for these individuals the program seemed to serve as a reinforcement for action initiated before attending counseling sessions. Most of the change in drinking occurred at the extremes. The proportion who reported drinking fewer than 8 drinks per week went from 42 percent to 62 percent, and those reporting 28 or more drinks per week dropped from 27 percent to 4 percent. Overall, the percentage of clients who consumed more than 14 drinks per week declined from 54.1 percent from the week before the program began, to 43.3 percent after the first counseling session, to 21.2 percent in the last week for which data were available.

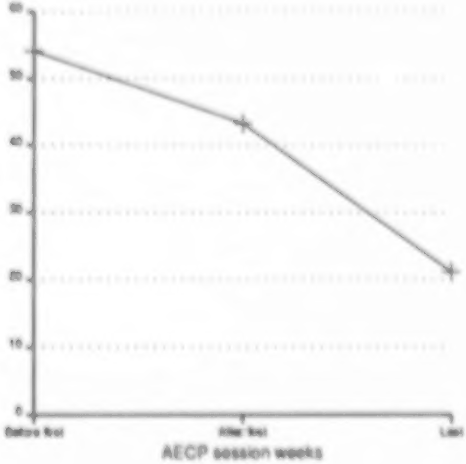


Figure 1. Change in clients' drinking (based on diaries of 47 AECP clients): The percentage of clients who consumed more than 14 drinks per week.

Four caveats are offered in relation to these results.

First, not all clients of the counseling program were residents of community 1. Although we could have restricted client membership to town residents only, we accommodated all interested persons (even if they lived outside town) as long as there was space available in a counselor's schedule.

Second, it was difficult to maximize the validity of the study because random assignment to control and treatment groups was not considered appropriate, and we felt it was unacceptable to obtain corroborating information from family, friends, or body fluid samples.

Third, the clients were encouraged to be candid about their use of alcohol, and there were no penalties (e.g., removal of counseling services or punitive responses by the counselor) if the client reported heavy consumption in the previous week. It is likely that those who dropped out of the program drank more, on average, than those who remained in, but there is no basis for concluding that the self-reported consumption data obtained during the counseling are generally invalid.

Fourth, of the 52 clients, only 62 percent attended all seven sessions, but 73 percent participated in at least four sessions.

Other Aspects of the Intervention

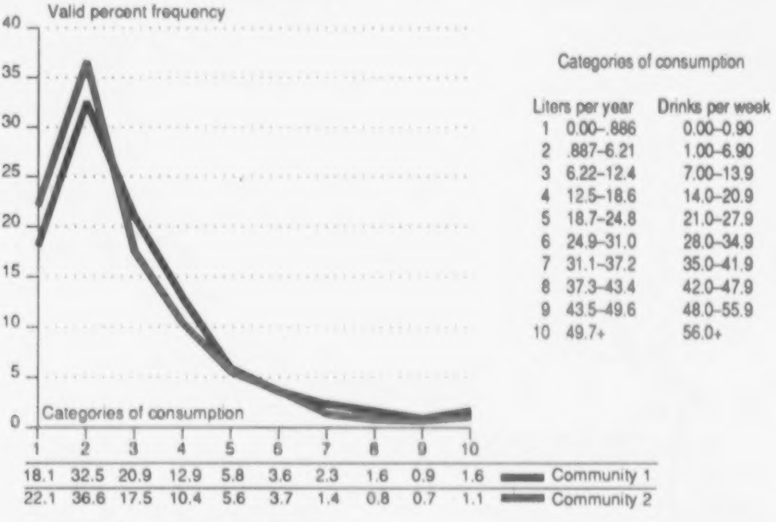
Various changes in the community were documented during the course of the intervention. For example, an increase in the number of opportunities to promote the intervention through media (free announcements), speaking engagements, training sessions, committee work, and consultation on alcohol issues in the community was noted over time. In addition, as the project progressed, contact was made with a wide range of groups, and community members demonstrated increased interest in facilitating prevention initiatives. A local server intervention committee was established to set guidelines for serving alcoholic beverages in licensed premises and at special occasions. Project staff met with union officials to promote responsible low-risk practices concerning alcohol consumption and to promote them through organizational safety committees. Staff also arranged for referrals to the program of persons convicted of drinking and driving through contact with the Crown Attorney and criminal lawyers.

Overall, alcohol issues became more prominent, not only in the newspapers (through weekly articles written by the project coordinator) but in the news generally. This increase in visibility stimulated an interest in alcohol problems among members of the local social service, health, and social issue committees, as well as among other groups not usually concerned with alcohol issues.

Survey Data

The following observations focus on the self-reported consumption of alcohol by persons who had been drinking in the previous 12 months. A combination of two measures (usual quantity and frequency of consumption) was used to produce a current annual estimate of alcohol consumption in liters of absolute alcohol (labeled Q-F). The subjects were also asked how many drinks they had taken in the past week (from 0 to 126); the number was then converted to an annual estimate of liters of absolute alcohol (or average drinks per week). This estimate is labeled W-Q. While the two estimates focus on different aspects of consumption—the former (Q-F) on typical quantity and frequency, and the latter (W-Q) on recent consumption—similar distributions emerged. The quantity-frequency measure (Q-F) produced uneven frequencies at the tail of heavy consumption categories instead of gradual tapering off as would be expected from the literature. This tapering off is considered to be in part, at least, an artifact of the derived nature of this variable. Therefore the graphs focus on the W-Q variable. Differences between the communities with time held constant are illustrated in figures 2 and 3, and changes over time are provided in figures 4 and 5. The categories along the X axis represent standard drinks per week or their equivalent in liters of absolute alcohol per year.

The distributions of the two communities differed at baseline (fig. 2) and also after the intervention (fig. 3), although the differences were somewhat greater at baseline (Giesbrecht and Wood 1989). Based on these measures, there appears to have been some movement in the responses for both communities, with somewhat greater change in community 1. The distribution curves in figure 5 indicate a moderating of alcohol consumption, with a decline in the proportion of consumers in categories 3 through 8 (seven drinks per week and more) and an



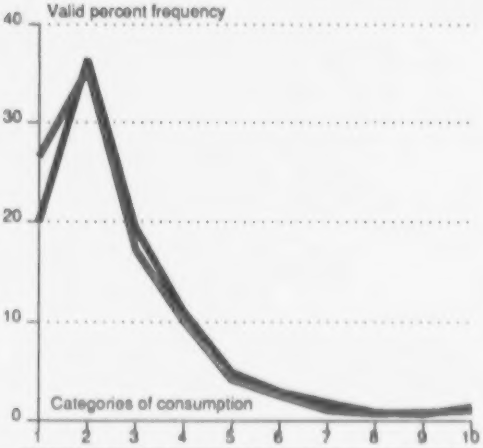
Categories of consumption

	Liters per year	Drinks per week
1	0.00–.886	0.00–0.90
2	.887–6.21	1.00–6.90
3	6.22–12.4	7.00–13.9
4	12.5–18.6	14.0–20.9
5	18.7–24.8	21.0–27.9
6	24.9–31.0	28.0–34.9
7	31.1–37.2	35.0–41.9
8	37.3–43.4	42.0–47.9
9	43.5–49.6	48.0–55.9
10	49.7+	56.0+

1	2	3	4	5	6	7	8	9	10	
18.1	32.5	20.9	12.9	5.8	3.6	2.3	1.6	0.9	1.6	Community 1
22.1	36.6	17.5	10.4	5.6	3.7	1.4	0.8	0.7	1.1	Community 2

Missing cases: Community 1, 7.2 percent.
Community 2, 4.9 percent.

Figure 2. Alcohol consumption in community 1 and community 2 at baseline survey (time 1) (standard drinks in the past week: W-Q).



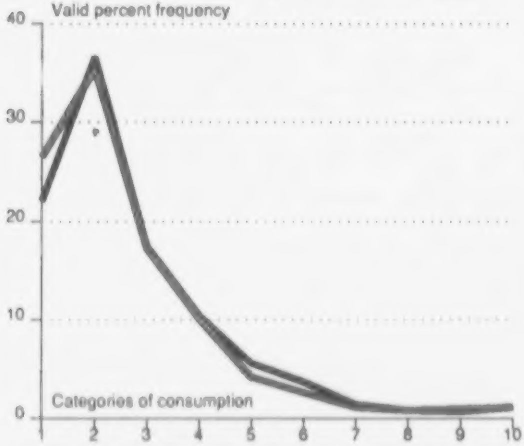
1	2	3	4	5	6	7	8	9	10	
20.1	36.4	19.4	11.1	5	3	1.9	0.9	0.7	1.4	Community 1
26.6	35.4	17.2	10.1	4.2	2.6	1.1	0.8	0.9	1.1	Community 2

Missing cases: Community 1, 8.6 percent.
Community 2, 6.8 percent.

Categories of consumption

	Liters per year	Drinks per week
1	0.00–.886	0.00–0.90
2	.887–6.21	1.00–6.90
3	6.22–12.4	7.00–13.9
4	12.5–18.6	14.0–20.9
5	18.7–24.8	21.0–27.9
6	24.9–31.0	28.0–34.9
7	31.1–37.2	35.0–41.9
8	37.3–43.4	42.0–47.9
9	43.5–49.6	48.0–55.9
10	49.7+	56.0+

Figure 3. Alcohol consumption in community 1 and community 2 at second survey (after intervention; time 2) (standard drinks in the past week: W-Q).



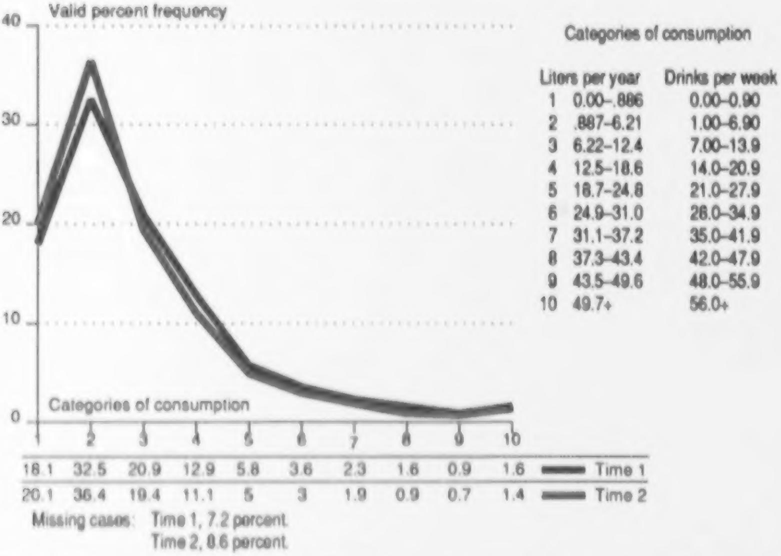
1	2	3	4	5	6	7	8	9	10	
22.1	36.6	17.5	10.4	5.6	3.7	1.4	0.8	0.7	1.1	Time 1
26.6	35.4	17.2	10.1	4.2	2.6	1.1	0.8	0.9	1.1	Time 2

Missing cases: Time 1, 4.9 percent.
Time 2, 6.8 percent.

Categories of consumption

	Liters per year	Drinks per week
1	0.00–.886	0.00–0.90
2	.887–6.21	1.00–6.90
3	6.22–12.4	7.00–13.9
4	12.5–18.6	14.0–20.9
5	18.7–24.8	21.0–27.9
6	24.9–31.0	28.0–34.9
7	31.1–37.2	35.0–41.9
8	37.3–43.4	42.0–47.9
9	43.5–49.6	48.0–55.9
10	49.7+	56.0+

Figure 4. Alcohol consumption in community 2 at baseline (time 1) and second (time 2) surveys (standard drinks in the past week: W-Q).



Categories of consumption

	Liters per year	Drinks per week
1	0.00–.886	0.00–0.90
2	.887–6.21	1.00–6.90
3	6.22–12.4	7.00–13.9
4	12.5–18.6	14.0–20.9
5	18.7–24.8	21.0–27.9
6	24.9–31.0	28.0–34.9
7	31.1–37.2	35.0–41.9
8	37.3–43.4	42.0–47.9
9	43.5–49.6	48.0–55.9
10	49.7+	56.0+

1	2	3	4	5	6	7	8	9	10	
18.1	32.5	20.9	12.9	5.8	3.6	2.3	1.6	0.9	1.6	Time 1
20.1	36.4	19.4	11.1	5	3	1.9	0.9	0.7	1.4	Time 2

Missing cases: Time 1, 7.2 percent
Time 2, 8.6 percent

Figure 5. Alcohol consumption in community 1 at baseline (time 1) and second (time 2) surveys (standard drinks in the past week: W-Q).

increase for categories 1 and 2 (fewer than seven drinks per week). The data in this figure are based on self-reported consumption among males for the 7 days before the survey (W-Q). While there was a higher proportion of missing values for W-Q, and the timeframe (1 week) would underrepresent the drinking of infrequent consumers, this was not a created variable as was the case for Q-F, and so there was no error arising from the combination of two variables.

Again, several caveats are offered about these preliminary results. Even though the change in community 1 over time is statistically significant (Giesbrecht and Wood 1990), these results represent only modest changes in the overall average annual intake (two drinks per week for W-Q). In addition, the two measures probably reflect overlapping but not identical aspects of drinking behavior, with W-Q (past 7 days) probably having greater specific accuracy but a narrower scope, and possibly confounded by higher noncompliance. Until the investigators can examine the representativeness of the respondents and the coverage of consumption, only tentative conclusions can be drawn about the decreases in consumption that seem to have occurred, for secular changes in consumption appear to have occurred during the study period. A slight gradual decline in the per adult rate of alcohol sales took place between 1983 and 1986. This decline seems to be reflected in the self-reported survey data presented in this section.

Aggregate Statistics

Community 1, which had the highest rate of alcohol consumption, also had the highest annual level of hospital admissions with an alcohol-specific diagnosis (table 3). Community 2 maintained a relatively stable rate of alcohol consumption in contrast to the high rate of police intervention in 1979–80, which dropped off sharply in 1981. Changes in police practices in community 2 were likely a more important factor in the drop than a decline in actual incidents. The annual data provide no obvious indication of a decline in community 1's consumption rate or alcohol-related problem rates during the time of the intervention that would distinguish it from communities 2 and 3.

Table 3. Rates of alcohol sales and problems among adults in the three study communities, 1979–86

Community	Range	Mean
1 (intervention)		
Alcohol sales[*]	18.44–20.12	19.12
Police statistics[+]	29.28–45.38	34.46
Hospital statistics[#]	13.60–22.60	18.75
2 (regular control)		
Alcohol sales[*]	13.57–15.39	14.51
Police statistics[+]	28.98–106.78	51.11
Hospital statistics[#]	4.90–12.60	8.83
3 (pure control)		
Alcohol sales[*]	16.92–18.80	17.67
Police statistics[+]	17.10–22.93	22.62
Hospital statistics[#]	10.50–14.80	11.85

[*] Liters of absolute alcohol per adult, 1980–1986.
[+] Alcohol-related offenses per 1,000 adults, 1979–1986.
[#] Alcohol-related hospital admissions per 1,000 adults, 1979–1986.

Alcohol sales data are difficult to interpret because during the course of the study a dispute between the workers and the province's three major breweries resulted in a lockout by the management and the closing of the Brewers retail stores. (The discussion of the 1985 Brewers' lockout is based on Giesbrecht and Conroy [1986].) These outlets sell beer to customers directly for off-premise consumption and also to licensed premises such as taverns, hotels, and restaurants for on-premise consumption. The brewers produce about 98 percent of the beer sold in the province. The lockout lasted from February 26 to March 26, 1985. Smaller breweries continued to sell beer from their production outlets, and some licensed premises had stocks of beer that lasted for a few weeks. The Ministry of Consumer and Commercial Relations arranged to expedite shipments of beer from the United States to the Liquor Board for sale to customers directly or to on-premise outlets. Nevertheless, the main supply ofbeer was dramatically curtailed for about a month.

A decline of more than 50 percent in the volume of domestic beer sales for March 1985 is recorded for each town, compared to the data for March from the previous 5 years (1980 to 1984, inclusive). Similar results are seen when expected sales are calculated using the ratio of March sales for a prelockout year to sales for several months for that year. It appears that for March 1985 the net decline in sales of all types of alcohol from the expected levels was as much as 75 percent in community 3, 46 percent in community 2, and 59 percent in community 1. Because community 3 is located near the Ontario-Quebec border, it is likely that there was less substitution of imported beer, wine, and spirits for domestic beer because residents were able to cross the border to purchase domestic beer from Quebec. Therefore the actual variation may not have been as great as suggested by the estimated 75-percent decline.

A drop of this magnitude, even for a month, has the potential for modifying drinking behavior for longer periods and confounding interpretation of the study. The fact that this natural experiment affected the level of alcohol use in all three communities is a small comfort.

Reactions and Responses to the Intervention by the Community

Based on field notes kept during the study, a transformation was evident in the response of community leaders to the project over the course of 1.5 years. It appears that there were at least three phases in the interaction between the project staff and the community leaders, particularly among those involved in dealing with social and health problems. Over time, suspicion and resistance to the project gave way to utilization and then to elaboration.

Resistance. The project had been introduced after discussions with the mayor, a hospital administrator, the medical officer of health, and the police chief. During the first months, extensive promotion of the study was undertaken through the media, door-to-door mailings, posters, and presentations, resulting in the recruitment of only a few clients.

Although the project staff emphasized the prevention goals of the intervention, the program was initially perceived as "treatment by another name." Some residents rejected it as an unwelcome intrusion into the conventional arrangements for handling alcohol problems in the community. Thinly veiled rejections were heard regularly during the first months, as in questions such as "So, how long will you be here?" Overall, only a few clients were referred to the program by physicians, despite concerted efforts on the part of project staff, including presentations at the doctors' business meetings, personal meetings and telephone reminders, a review of referral procedures, preparation of a special brochure for doctors' offices, and a display poster for doctors' waiting rooms.

Resistance also took the form of disregarding the service. Officials had agreed to offer the AECP service to all persons convicted of alcohol-impaired driving, regardless of other sentences. In fact, program participation was made a condition of probation in only a small number of cases, primarily as a result of the probation officer's own initiative.

Active resistance was manifest in criticisms of project staff at meetings and during one-on-one conversations. Some resistance arose because the program was different from Alcoholics Anonymous (AA) and because the project was seen by some as interfering in the "turf" of professionals who were routinely involved in service delivery. Concern was also expressed by those who perceived the intervention as not being tied to the community (providing no community ownership) and because it was believed that the project would blacken the community's name by drawing attention to heavy consumption and alcohol-related problems.

Utilization. Positive responses to the initiative became more evident some months after the intervention had begun, when staff were actively promoting greater awareness of alcohol issues, prevention agenda, and the counseling service. Utilization was gradual, but with time clients began to be referred or came on their own. Eventually, community groups began to request presentations and project staff were asked to join the various committees concerned with social and health issues.

Elaboration. Some developments occurred in the community that were related to the intervention. In addition to project-specific coverage, there was overall increased media activity pertaining to alcohol issues, and effort was made during the project to obtain Ministry of Health funding for an assessment-referral and case management center. The town council reviewed serving practices and policies, and local professionals expressed interest in seeing a continuation of the services introduced by the project.

Some of this activity was surprising to the project staff, because information received before site selection had indicated that the intervention community perceived the operation of its treatment facilities to be an adequate response to alcohol problems. The town had two small AA groups and some facilities for treatment of patients in a psychiatric unit of the local hospital, but there was very little expression of concern about alcohol problems from the general public. However, some professionals (mainly younger doctors and social service personnel) showed interest in the project from the start. As relative newcomers to the community, they appeared to have taken note of the high level of drinking, the tolerance of heavy alcohol consumption, and inadequacies in the local responses to alcohol-related complications.

Within a few months of the start of the intervention, several committees began to plan for the expansion of alcohol treatment services and education programs for the public. Some "modeling" activity appears to have occurred; for example, a workshop for the clergy and plans for server training were introduced after similar activities had been offered through the project. At the outset, project staff had wanted to establish a local advisory committee to make the prevention activities more effective and efficient, but little community interest was then evident. However, in the last 3 months of the intervention, several local people agreed to come together in an ad hoc group to develop and submit a proposal applying for outside funding to establish a program along the basic lines that had been offered in the prevention project. Thus some of the project's prevention initiatives seem to have had clear implications for local efforts, especially as the field work of the project was winding down.

Interpretations

After a major field project is completed and the results begin to come in, it is disappointing to see equivocal findings emerge rather than the clear, strong outcomes that were hoped for when the plans were developed. The purpose of this paper, however, is to seek some interpretations of the findings. The interpretations that follow relate to the drinking environment, community responses to drinking-related problems, the design of the intervention, and the goals of the project. First, some general comments about the practical limitations of the project are offered.

Practical Limitations

Choice of community. Various factors associated with the choice of community for the intervention might have altered the effects of the intervention. It might have been possible to find a community in which there was a great concern with alcohol issues or in which recent events, such as serious accidents or disruptions related to alcohol use, might have promoted more interest in prevention programs. However, such a location might have proved to be inappropriate because of high travel costs and logistics or because of the size of the population and the attendant costs of primary data collection. Confounding might have occurred in dealing with already-existing prevention or treatment activities. Communities also needed to be screened for erratic patterns in apparent yearly consumption that could have undermined comparisons drawn over time or between the intervention and control communities. In addition, a community with high potential for accepting prevention initiatives might have been quite different from potential comparison communities on other grounds such as demographic composition, migration patterns, and community growth or decline.

All of these issues were encountered during the selection process. It would probably have been easier to jettison some of the research constraints and to go where the "action" was expected. In the end, the community chosen for the intervention was suitable on some criteria but seemed to lack enthusiasm about primary and secondary prevention.

Project staff and other resources. Plans to develop prevention activities at the local level were influenced by the skills of the project staff as well as by the resources available in the community. For a variety of reasons, including lessons from other projects (e.g., Wallack and Barrows 1981), the decision was made not to subcontract the intervention component of the project. In principle this might have been a mistake; in practice, however, it was clear that the views of the project staff with regard to both primary and secondary prevention were not fully compatible with the community's attitudes toward the delivery of alcohol services. Specifically, local residents had difficulty with the notion of community responsibility for alcohol problems; as a result, they tended to be more concerned with case finding, the labeling of deviant drinkers, and educating young people.

Community interests versus level of funding. Another practical consideration was that the goals of the project may not have been fully aligned with the interests of the community. The main objectives of the project were to gather relevant research data, to implement a prevention program that could be assessed by these data, and to draw out recommendations and findings for developing prevention programs, theory, and research methods. In contrast, the community leaders appeared to be interested in establishing services to address alcohol problems. The project staff assisted the community leaders with an application to seek funding for such a service, but the research funds used for the time-limited project were not available to underwrite a large-scale, permanent, local service for alcohol-related problems. A number of community leaders expressed disappointment when the project was completed and no further interventions were available.

Skills in community development. As the project staff quickly discovered, the preparation and implementation of community development activities and the stimulation of interest in prevention initiatives require highly specific skills. It was difficult to integrate community perceptions of alcohol issues with the different perceptions that might be required to bring about changes in behavior among heavy consumers (Giesbrecht and Pranovi 1986). As it turned out, the failure to more fully accommodate the community perceptions may have compromised the potential for achieving any changes in behavior. It may be possible to introduce new approaches or strategies into a community, but making them work requires considerable skill, time, and experience.

Project administration. The initial plans were to conduct the study in northern towns with economies based on primary industry, but complications in project administration constrained the selection of study sites in this area. Following this change in venue, development and implementation of the intervention became predominantly the responsibility of the researcher and his colleagues.

Alcohol Use Environment

The data from the surveys, as well as sales of alcoholic beverages, suggest that there was heavy drinking in the intervention community. Many communities in Ontario, however, likely have similar or even higher rates. Whereas the provincial sales rate was 11.11 liters of absolute alcohol per adult (aged 15 and older) in the 1982–83 time period (ARF 1985), a level of 18.4 to 20.2 liters was found in the intervention community for the same period (see table 3). This number is inflated somewhat by purchases made by nonresidents (who were not included in the denominator in calculating the rates), as well as by tourism in the summer months. Even if the figures for June, July, and August are subtracted from the sales and an average of May and September sales substituted, the estimated annual rate for 1983 is still 18.02 liters per adult, compared to 19.46 liters for unadjusted sales.

Evidence of the importance of alcohol use in the social life in the community comes from the survey data. In the 1984 survey in community 1, one-third (34.7 percent) of the adult males claimed that they drank at least four or more standard drinks on drinking days and 37 percent admitted to having been "a bit intoxicated" once a month. Almost 82 percent of the respondents had taken a drink in the 7 days before survey, and 14 percent admitted to drinking more than 21 standard drinks over the past 7 days. In addition, a substantial proportion of all respondents to the 1984 survey in community 1 admitted to the following over the past 12 months (responses to "frequently," "occasionally," and "seldom" options combined): driving a motor vehicle after drinking a lot of alcohol (46 percent), drinking in a car (termed "gravel running") (35 percent), getting into arguments after drinking (31 percent), and upsetting a wife or girlfriend about the respondent's drinking (30 percent). It appears that a short-term but nevertheless intensive prevention project had to confront ingrained drinking habits, a high proportion of heavy-drinking consumers, and therefore strong resistance to an effective community-wide intervention.

Community Responses to Drinking-Related Problems

There seemed to be an acceptance of frequent or heavy alcohol consumption in the community. For example, the newspaper did not indicate whether alcohol was involved in motor vehicle incidents. Even early-morning single-car crashes (in which impairment was very likely to have been an important factor) were reported as "losing control." Furthermore, there was a high tolerance for drinking-related incidents. Persons convicted of drinking and driving were perceived by some officials as "unlucky." Driving after drinking, drinking in a car, and going in a car to a drinking party in an isolated spot and then driving back were not uncommon behaviors. The survey responses probably provide a conservative estimation of the frequency of occurrence of such activities.

In contrast to the apparent frequency with which alcohol-related risk taking occurred, community leaders clung to a narrow perception of the makeup of the problem drinker. Persons who experienced a lapse in control of personal affairs because of drinking (e.g., neglecting work, family, household finances, or friends), and/or who had received treatment for alcohol problems, were likely to be identified as having a drinking problem (Giesbrecht and Pranovi 1986). Heavy consumption in itself, risk taking, and confrontation with others while under the influence of alcohol were not considered to be indicators of problem drinking. In general, these perceptions provided an additional impediment to implementation of a prevention program.

Design of the Intervention

The prevention initiative in this study went well beyond the average level of activity typical of community-generated programs on alcohol issues. In fact, it would have been unusual to find a community of the size in which the prevention component was conducted that had established an alcohol abuse prevention program with the scope of the study intervention. In spite of this wide scope, however, the project may still have been less intensive than was required to modify the rate of consumption and community resistance to prevention initiatives. A longer, more strongly community-based and less explicitly research-oriented endeavor might have been required to achieve a change in alcohol use.

The intervention was a key component of a multiphase research project that, by its nature, constrained the scope and extent of the intervention. For example, to avoid contamination of the responses in the post-intervention survey, quantitative information was not provided to the general public about the aggregate rate of consumption in the community, nor were quantitative guidelines for low-risk alcohol use publicized. Information about the latter, including the estimated proportion of persons using alcohol at high-risk levels, combined with local data on aggregate rates of problems or alcohol-related incidents might have been effective in stimulating greater interest in prevention (Giesbrecht and Conroy 1987).

The research requirements, however, were not the only aspects of the intervention that may have reduced its impact. The community development and community mobilization aspect of the intervention probably did not receive sufficient emphasis. Activity in these areas was just beginning by the time the counseling service was well under way, and a much longer lead time would probably have been necessary to build an adequate foundation for community development. A more detailed overall plan should have been devised that not only focused on the proposed messages and activities but also explored conceptually, and through extensive discussion with local people, various strategies concerning the prevention content and the implementation of the intervention.

In light of the constraints to achieve rather substantial goals during a short time, a "blitz" type intervention evolved; in hindsight, however, it can be seen that the community would probably have been more amenable to one that was elaborated at a pace more in keeping with expanding local awareness of alcohol-related issues.

Time constraints proved to be a major problem. Considerable time is usually required to develop interest in prevention. The importance of this process is acknowledged by programmers (e.g., Douglas 1986) and it was confirmed by project staff in an interim assessment of the field experiences (Giesbrecht and Conroy 1987). It would have been advantageous to have a period of unobtrusive, low-profile community assessment and intervention development between the time of site selection and the time of the baseline survey. This alternative design would have allowed for better preparation for the intervention, eliminating the long delay between the first survey and the actual start of the AECP program and the other activities. Nevertheless, it is possible that pre-intervention activities occurring in only one community might have introduced bias into the baseline survey, and such activity in more than one town might have led to the emergence of independent prevention activities in the control town. As it was, the communities were selected in fall 1983, and staff who were primarily concerned with the logistics of the two sites did not have sufficient time for extensive consultation with the community about prevention planning.

Matching Goals and Strategies

The conditions under which a modification in the distribution of alcohol consumption might be expected over time have been reviewed by Skog (1985b) and were illustrated by Norstrom's (1987) comparison of two Swedish surveys. A major change in a crucial alcohol regulatory feature, affecting all consumers in Sweden, produced a change in the distribution. (The rationing system established during World War I appeared to have produced a small dispersion in the distribution of consumption.) This distribution seems to have changed after the system was abolished in 1955, and the later survey produces values that better resemble the distributions seen in other countries.

The minimal requirement, then, for a change in alcohol consumption may be an intervention that cuts to the heart of the alcohol-related culture in the community, either by dramatic regulatory changes or by modifications in the handling of regulatory procedures. Alternatively, a social movement with strong support at the lay level as well as from key professional and business sectors may provide the impetus for change. Either of these occurrences appears to be requisite in order to change the drinking behavior of a sufficient number of heavy drinkers in the community, as well as to provide potential for a wider impact that could be captured in a post-intervention general survey and in aggregate trend data.

The ideal might well be a combination of regulatory changes and a social movement, supported by an educational and media component promoting the two efforts and their complementary benefits (Giesbrecht 1987; Giesbrecht and Conroy 1987). Because the most important alcohol regulations in Ontario are, or at least were, controlled by the provincial government, it is difficult to envisage a major change that would affect only the heavy consumption in the intervention community and leave unaffected the control communities. Even if such a change were feasible, it is difficult to believe that any community, particularly with above-average alcohol use, would comply with further restrictions in availability of alcohol limited to that community alone.

In this study, a persuasion/education intervention was used because it was considered to be the only reasonable option under the circumstances. With more time, it might have been feasible to influence local regulations in serving and selling practices. Because a voluntary strategy was chosen rather than a strategy that included addressing the regulations that play a key role in availability, a much less powerful approach had to be employed.

In other words, the research conditions and the local circumstances that placed constraints on the interventions substantially reduced the potential for achieving the main goal of the study. In seeking to combine an intervention with evaluation, it is seldom likely that, when implemented, the resulting activities will constitute an appropriately balanced enterprise. This study is no exception. It is likely that an uneven balance between the intervention and research activities will be evident to the observer. For example, more interaction between the components of the intervention might have been attained and a longer lead time scheduled to facilitate community involvement in the study. One can envisage circumstances in which the results would demonstrate unequivocal conclusions about the impact of the intervention on the overall distribution of consumption, but these circumstances would likely have to resemble some combination of the following: a high degree of local concern about heavy alcohol consumption and alcohol-related complications, innovative modifications in regulatory measures, and strong community mobilization in response to alcohol issues. Such an approach would likely be more effective than the techniques of education and persuasion primarily used in the course of this prevention project.

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Planning, Development, and Process Issues in the Rhode Island Alcohol-Related Injury Prevention Project

Sandra L. Putnam

Project Description

The Rhode Island project, the Community Alcohol Abuse Prevention Project (CAAPP), has been funded for the past 5 years by a cooperative agreement among the U.S. Centers for Disease Control (CDC), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Rhode Island Department of Health (RIDH). The rationale and basic goals of the project were set out by the original Request for Proposals (RFP). The RFP called for a program aimed at "...Development of a Mechanism for the Surveillance, Identification, and Prevention of Alcohol-Related Health Problems at the Community Level..." over 4 years. The RFP further specified an indepth epidemiologic study of selected risks and benefits of alcohol use in two communities, including identifying risk factors or groups of people at risk for adverse outcomes; developing mechanisms to prevent morbidity and mortality associated with alcohol; and using a quasi-experimental research design to evaluate the impact of an intervention/prevention program in one of two communities in terms of its effectiveness in reducing alcohol-related morbidity and mortality.

The Rhode Island community-based, alcohol-related injury prevention project integrated a conceptual framework and theoretical model for community change with a systemic approach to reducing alcohol-related assault and motor vehicle crash injuries and deaths. Injury outcome changes were measured by continuous surveillance by project staff of police, medical, death, and medical examiner's records in three study communities.

The intervention programs were designed to reduce injury morbidity and mortality and also to reduce the incidence of intoxication and the likelihood of combining drinking with such high-risk behaviors as driving. Strategies combined sociocultural environmental modification affecting group norms and behavior; regulatory mechanisms in the form of increased law enforcement and mandated penalties; education and information as a primary method of persuasion; and economic incentives and disincentives through the use of legal liability as a lever for gatekeeper training and responsibility.

Interventions focused on changing knowledge, "enabling" attitudes, and behavior of two gatekeeper groups: servers of alcoholic beverages and the police. The strategies directed at the police included increased enforcement of Driving While Intoxicated and liquor laws through the use of sobriety checkpoints, radar speed patrols, and selective enforcement of dram shop laws; and increased police training on sobriety testing, alcohol reporting, crash investigation, and liquor law enforcement. Server programs included written policy adoption, server training and awareness, certification, and publicity.

The theoretical basis for the interventions rested on the notion of the community as a system of influence, with the police and the servers of alcoholic beverages at the front line of alcohol-related injury prevention. The police are responsible for DWI and other liquor law enforcement, while liquor licensees and servers are responsible for upholding dram shop laws—for not serving alcohol to minors or to visibly intoxicated persons. Reducing enabling of alcohol abuse by these gatekeepers by changing their knowledge, attitudes, and behavior was expected in turn to reduce the heavy drinking and problem-drinking behavior of their clients, especially in high-risk situations, thereby reducing alcohol-related motor vehicle crash injuries and deaths, assaults/homicides, and other alcohol-related events and injuries. The development and progress of these programs at the community level are discussed in this paper, including problems and barriers to implementation and strategies to assure community acceptance, cooperation, and ownership of the project.

Initiating the Project

Three major challenges that related to changes in the RFP charge beset the early stages of project development. First, no provision was made for a planning or development phase by the funding bodies. This lack resulted in the impression that the project was always behind schedule. Another effect was the need for "zigzagging," that is, changing program directions occasionally and precipitously, which gave an ad-hoc sense to the project. Second, the original charge of studying alcohol-related health problems was limited to a more manageable focus on alcohol-related injuries, especially assaults and homicides and motor vehicle crashes, with important input from colleagues at RIDH and CDC, namely, Ian Rockett, Ph.D., M.P.H., and Gordon Smith, M.D., M.P.H. This change was beneficial to the project, yet required negotiation and readjustment. Third, rather than two communities, three Rhode Island communities were matched on a range of baseline indicators of sociodemographic factors, alcohol consumption, and injury and other alcohol-related morbidity and mortality incidence rates to allow for one intervention and two control sites to provide better comparisons. Other changes from the original RFP included applying for and receiving a grant of wrap-up funds. No focus on alleged benefits of alcohol use was maintained past the RFP, since costs far outweighed any possible benefits.

The model of the Stanford and Pawtucket Heart Health Projects was adapted to alcohol-related injuries by the project director in developing the project. Combining sound research design and evaluation principles with an intervention capability unique in injury prevention represented an important strength of the project.

After strict selection criteria were used to choose three study sites, one was selected randomly and publicly as the intervention site to demonstrate fairness. A public and symbolic gesture of nonpartisan choice of an intervention site was required. Not only mayors, but also police chiefs, hospital staff, and other community leaders were interested in having their community selected as the intervention site. The two communities that were not selected were willing to continue to participate in the data collection process for two reasons. The data collection had been presented as an end in itself, useful for the broader needs of each community over and above the CAAPP research. With the promise of returns of data analysis results in the form of feedback to the community sources from which they were gathered, and with the suggestion that control communities would be included in future intervention programs should the project be funded for a second 5-year phase, community leaders were appeased, and all remained cooperative.

The organization and staffing of the project included the hiring, 3 months into the first grant year, of the project director, Sandra L. Putnam, Ph.D., followed by a full-time clerical assistant and a part-time student research assistant. The most difficult start-up phase of the project was conducted by this skeleton staff. This occurrence came about in part because of an absence of prototypes of alcohol/injury projects to model after and the concern that hiring key full-time professional staff at too early a stage in project development might result in inappropriate staffing and would lock the project into a fixed form prematurely.

The first step in project development, after selecting three study sites, was setting up the surveillance systems to monitor alcohol-related injury events from police, hospital, death, and medical examiners' records, and conducting surveys, including the design of questionnaires, drawing of samples, and protocol development. Surveillance data were abstracted by project staff from existing medical, police, and death records continuously over the entire study period. These data could not be obtained from published data sources because they needed to contain information on alcohol involvement, to be based on residents of each of the three cities for computation of population-based incidence rates, and to be disaggregated for analytic purposes. Twelve data sets were created to guide identification of high-risk groups, to target interventions, and to evaluate program effectiveness.

The second and juxtaposed step was to use the preliminary results of the baseline data collection to develop targeted interventions in the one community. In reality, research protocols were developed only slightly before intervention protocols because of time constraints. Therefore theory and existing programmatic experience, as much as research results, drove the initial intervention program development. Ultimately a staff of 12 full-time and part-time personnel was assembled by year 2 (mid-1986), including a full-time community coordinator, several records abstractors, a research analyst, a data entry operator, a systems analyst, a statistician, three server trainers, student interns, and an Employee Assistance Program (EAP) consultant.

Another issue in staffing the project was the fact that the bureaucratic requirements of the State health department extended to the project, even though it was a time-limited, federally funded project, anomalous in many ways from ongoing State programs and functions. This situation made it difficult to fit the project into its institutional home. Requests for positions needed to be congruent with the constraints of the civil service system, a time-consuming and often impossible task. The alternative was to hire staff as consultants, who would bill the project monthly for services rendered and receive no benefits. While this billing procedure provided a good Management Information Systems (MIS) tracking source for the project director, it used up valuable time and effort on the part of staff each month. The hiring necessities resulted in low staff morale, high job insecurity, and differentiation and isolation from the State employees. Purchasing equipment and services expeditiously was also difficult; although, to balance the scales, no overhead was required to be paid to the State.

A related problem faced by the project lay in the need to collect new data on community residents to compute population-based incidence rates. This procedure was expensive, time consuming, and labor intensive and resulted in the apparent over emphasis on research staff at the expense of intervention program staff, inevitable in such projects. This emphasis was not a disadvantage, because the ability of the community coordinator to mobilize effectively community members to share agendas and work toward project goals required skill and expertise more than additional staff.

Data on alcohol involvement in injury events were inadequate and underreported. This problem was never satisfactorily resolved, although subjective report forms for alcohol influence were introduced in all three police departments to document officers' assessment of alcohol in non-DWI arrests. These forms resulted in a doubling of the arrests reported as alcohol related compared with police records alone.

Three possible objective tests for alcohol consumption were pursued by the project director for introduction in the emergency rooms (ERs) and police departments: the alcohol dipstick, the portable breath tester, and the passive alcohol sensor. These efforts failed because of insurmountable problems in protection of human subjects and informed consent. Also the FDA approval status of the dipstick technology and its availability, safety, and acceptability caused concern. Subjective report forms were used to improve the overall quality of the alcohol data. Despite the problems involved, improved alcohol reporting is vital in any such project at the outset. Otherwise, whether observed changes are caused by better alcohol reporting or by changes in alcohol-related events is not clear.

Staff continuity is important in a project's stability and progress. The same principal investigator and the same director led the project through nearly 4 years. However, the project officer at CDC changed four times over the course of the study (although the NIAAA project officer remained the same), and the affiliation of the study with the Injury Epidemiology and Control Branch at CDC was a welcome but relatively late addition. Several other personnel changes occasioned by staff seeking more secure jobs that required less travel and provided more benefits resulted in increased burdens on the project director in recruiting, hiring, and training new replacements, a problem familiar to project managers.

Other problems related to the satellite location of the intervention component of the project. The community coordinator (two were hired sequentially over the project's history), who was responsible for implementing the intervention activities at the intervention site, occupied an office at the city hall donated to the project by the mayor. This space was a mixed blessing. It showed the mayor's support for the program and saved the project the cost of leasing an office. However, the distance between project headquarters and the field office (15 miles) led to difficulties in supervision, accountability, and quality control, and increased the vulnerability of the community coordinator to co-optation by community interest groups. If the field coordinator's identification with the core project or his or her commitment to project goals is diluted, the program can lose effectiveness.

An important issue considered in this project concerned whether the community coordinator and other intervention program staff should be recruited from the intervention site and therefore be indigenous. The timing of the selection of the intervention site (not until 1-1/2 years into the project so as not to bias data collection) precluded the possibility of such hiring for this project's community coordinator. Nevertheless other key personnel, namely server trainers and the EAP consultant, were respected members of the intervention community. Some benefits to this plan were instant access by the project to the culture and the formal and informal organization of the city. The disadvantage was automatic partisanship in an already politically volatile situation. The presence of an objective, nonaffiliated community coordinator from another community ultimately proved to be an asset, when local politics proved a very strong and pervasive source of conflict and lack of communication in this small, historically inbred and ethnically homogeneous community.

The point of entry for the project in the intervention community was from the top down. Entry was gained by early and ongoing meetings with the mayor, the police chief and the planning group he established, city councilors, liquor licensees, hospital administrators, chief ER physicians and nurses, and representatives of community alcohol treatment and prevention groups. Much of the same top-down effort allowed ease of access for the project director and the principal investigator in the other two study sites and was essential to permission seeking, proper etiquette and protocol, and subsequent project acceptance.

The intervention strategies were developed to fit the two gatekeeper communities, defined as sociocultural and occupational groups within the intervention site. In each case, programs were developed to meet project goals, with elements negotiated with key opinion leaders specific to each group to ensure their acceptance and ownership.

However, the two gatekeeper groups were very different in their subcultures and orientations, and these differences required understanding and flexibility in developing and implementing effective and workable strategies for each group. The police are a quasi-military group, a highly bureaucratized civil service organization, with strict standards of recruitment and training, fixed ranks for promotion, a single and clear line of formal authority, and a not-for-profit community service motive as law enforcers. Servers of alcoholic beverages are nonprofessionals with minimal standards for recruitment and training; they are frequently employed in economically marginal establishments at low wages, with low job security and few benefits. A for-profit motive operates here in that much of servers' income comes as tips from customers. The job is characterized by lack of union representation, high staff turnover, and low rewards, and frequently attracts high proportions of alcohol abusers.

The fact that a project run through a State department of health was attempting to change knowledge, attitudes, and behavior of two groups so rarely encountered by public health professionals caused challenging problems for staff members. The major difficulty in working with the police at first was project staff credibility as outsiders, i.e., not being police officers. This difficulty was a particular problem for female professionals from RIDH. Not being indigenous or native to the community gave rise to "the new kid on the block" syndrome.

However, after exposure, discussion, data sharing, and the purchase of needed equipment, the police chief proved most cooperative and assigned very conscientious and dedicated police professionals to work with project staff, including the operations officer and the training officer who met biweekly in planning and information sessions with the project director and the community coordinator. The only disadvantages or difficulties then encountered related to problems of police staff shortage, endemic in the department, which led to difficulty in recruiting officers to volunteer for project-sponsored training programs and selective patrols. Working within the constraints of police manpower shortages and prior commitments was problematic, and reinforced for us the fact that throwing money at problems does not solve them (at least not at the funding level of the project).

The servers of alcoholic beverages proved an intransigent group at first. They were difficult to motivate and resisted the classroom model of training. When their time from work was paid for by the owner or manager, more attended the 5-hour responsible service training program (developed by the National Highway Traffic Safety Administration (NHTSA)) that the project offered free of charge. "Why do we need this anyway?" was the dominant objection. Incentives for licensees to release their servers for training and to convince servers to attend sessions were important. Just as the police had responded to the project's ability and willingness to provide equipment, such as a second breath analysis machine and protective cones and barrels for sobriety checkpoints, items that could be purchased outside the police budget, so too, the servers responded favorably to release time by their employers for training and to the granting of certificates upon completion signed by the project staff and the trainers. Newspaper publicity, which was frequent and favorable for the police and server programs, was also a positive incentive to assure participation and to reward both groups.

On the negative side, fear of legal liability could also be seen to motivate police officers to accept training on the role of alcohol in police work and liability issues in dealing with intoxicated citizens. Likewise, servers of alcoholic beverages were spurred to seek training in unprecedented numbers after a $2 million civil law suit was filed under the Rhode Island dram shop law by the mother of a minor who was allegedly served in a local bar and fatally injured in a single vehicle crash in the intervention community.

Lessons About Project Process

To mobilize community opinion leaders, the issue of tapping into their self-interest to motivate changes in behavior was explored. Besides specific incentives, three factors were essential to mobilizing local activity and commitment. The first of these was explicit and unqualified (carte blanche) support from the top of the organization—the mayor and police chief, on one side, and the owners and managers of liquor-licensed establishments, on the other.

Second, finding common ground was necessary for shared project goals. Goals are more easily shared when they are humanitarian (such as reducing injury and death in the community) or are self-protective (such as reducing individual or group legal liability and the chances of law suits). Goals of reducing alcohol consumption and problem drinking are not easy to inculcate; they hit upon the denial factor in many subcultures. These goals also evoke concerns about prohibitionism, and are less likely to achieve widespread and constructive commitment and consensus.

Third, positive sanctioning and community recognition of changes were needed. Publicity for project events, with names, dates, places, and faces figuring prominently, was more important than vast, expensive, usually unfocused, informational or educational campaigns. This publicity taps into the competition phenomenon ("If he can do it, so can I"), and creates ripples of change in a small, intimate community. Publicity through local media is usually free, and local newspaper reporters and talk show hosts needed to be cultivated.

Capitalizing and building on the strengths of the community and on the natural controls that already exist in terms of behaviors and policies of key stakeholders and programs is very important. These strengths were identified and supported, and community leaders were recruited as project allies and informants. The Mayor's Task Force on Drug and Alcohol Abuse and the local City Council were two examples of preexisting positive factors.

The need to avoid working at cross-purposes, while maintaining independence and boundaries to avoid co-optation, was essential. The problem of redefining the police and server roles to include a proactive focus required help in overcoming the fear held by internal change agents that innovation will make them marginal or unpopular. For example, the police would not agree to patrol local bars at closing time because of the image of harassment it might present to legitimate business owners and taxpayers. Sensitivity to needs and priorities of local groups was required to be translated to CDC and NIAAA project officers. Project officers being far removed from the action depended on the project staff's interpretation of the local scene and sometimes may have harbored unrealistic expectations of possible changes and the time to make them.

Shifts of focus occurred in the project, particularly in the early stages of uncertainty and rapid development. This situation required great flexibility among project staff, patience by everyone, and forbearance by community leaders. Coordination and communication across three levels, from the community level to the project to the Federal sponsors and back down again to the community, required major translation skills. The potential for misinterpretation and misunderstanding was immense but fortunately was rare. Personnel problems within the project sometimes resulted from changes in direction or emphasis, for example, staff who had learned and understood their job in one way believed they had just mastered it when changes were required in some method or protocol. This situation happened with both the program intervention staff in developing training and other programs adapted and tailored to the needs of local services, and also occurred with records abstractors when unforeseen changes occurred in data collection mechanisms.

Extensive human subjects review and clearance by the RIDH Institutional Review Board (IRB) was necessary because the volatility of the alcohol issue; the potential stigma involved; and the requirement for collecting new survey data on high school students, a general population sample; and a sample of ER visitors, arrestees, and crash victims in three sites. The IRB was formed to deal with the knotty issues of this and other projects. The review process took excessive time and energy and resulted in one of the most protected sets of data collected in the RIDH. The process also reflected a more conservative perspective than often found in academic environments.

Conflicts in perspective occurred in the project from the start—a frequent consequence of interdisciplinary research efforts. Some areas of conflict included differences in the nature and course of alcohol-related health problems (in contrast to non-alcohol-related illnesses and injuries) that required greater care in accessing data and different etiologic, preventive, and therapeutic models; differences in the social scientific model versus the traditional medical models of disease etiology and prevention; differences in the administrative and bureaucratic perspective represented by a State agency and that of an academic research setting; and differences in the requirements of a research project with a community intervention component.

The need to apply for single-year funding from CDC/NIAAA was a major handicap, involving an annual 3-month loss of personnel time and resources to the reporting and application process. While this need provided an excellent and complete record of project activities essential for replication purposes, it interfered with the momentum and forward progress of the project. The uncertainty of obtaining the requested or required level of funding, the difficulty of planning ahead under such circumstances, and the lack of long lead times to develop research or program activities were problematic. They made it difficult to attract and keep qualified staff members. They led to an atmosphere of insecurity and unpredictability that was demoralizing for staff and affected credibility in the community.

The world view of program people and researchers can be diverse enough to make them unlikely partners. When, as in this project, the director is a researcher and is responsible for supervising both the research and intervention components of the project, the research emphasis may outweigh the program emphasis. Because CAAPP was a demonstration research project, such a supervisory arrangement and emphasis was necessary and important. Different emphases with different challenges emerge if the project director is a community organizer or program person managing the research component or an administrator managing both research and intervention components. In whatever scenario, a single line of authority must be maintained, with no dilution of the power or authority of the project director by the principal investigator or the project officers. Otherwise, too many cooks will spoil the broth.

The Aftermath and Recommendations

Issues of protection of human subjects were one of the major stumbling blocks throughout the project, which were related to sensitivity issues surrounding alcohol use and abuse and the RIDH's role in collecting data on alcohol use and abuse. Problems were encountered in efforts to ascertain levels of alcohol use in subjects. They were also manifested at the community level. Indeed, a promise was required on the part of the project that neither control community would be referred to by name but rather as "Community A" and "Community B" to preserve their privacy, to prevent unfavorable comparisons, and to eliminate the potential for negative publicity in published reports from this study.

Methodological issues faced were similar to those faced by the Heart Health projects. First, an *n* of three communities and four points (years) in time was extremely problematic for statistical analyses. Another major problem in the interpretation and analysis of the research results was the difficulty in determining whether declines in observed injury rates reflected changes in law enforcement or server practices attributable to the project or whether they reflected changes in the organization of police and server work or in the actual incidence of injury in the community.

Other essential questions related to whether 2 years of preintervention data were sufficient to detect changes in injury morbidity and mortality trends.

The related question was how many years of postintervention surveillance are needed to pick up program effects. Whether 2 years of program intervention was sufficient to cause desired changes was also unclear. The synergism and the concurrence of mutually reinforcing intervention strategies was seen as maximizing program impact, while at the same time making it impossible to separate individual program effects (did police programs work better than server programs?). All that can be said is that systemic, multifaceted programs produce or do not produce certain outcomes. Seasonal effects over a 2-year intervention period also confound efforts to distinguish program influences. A research design involving different interventions in two communities, with one as a control, would help resolve this problem, although interventions are both labor- and capital-intensive, and the project's budget did not allow for this possibility.

The replicability and transferability of this study is reduced by what was one of its greatest strengths in the implementation phase. As noted, the servers' resistance to training was overcome dramatically, when an alleged illegal act of reckless service to a minor resulted in the motor vehicle crash death of a local man and the filing of a $2 million civil law suit against the bar owner and the server. While this tragic event increased program acceptance, it makes replication unlikely.

A critical variable for program acceptance of both policies and server training among licensees was the type of business establishment or class of license. The uniform nature of their business and the single major issue of alcohol sales to minors resulted in the best program acceptance among package store owners. Owners of restaurants were also early adopters of the program because of the restricted nature of drinking in restaurants and existing sanctions against intoxicated customers. Bars and private clubs were harder to reach, particularly the economically marginal bars, which were often sites of heavy, regular, and sustained drinking, and were labeled "high-risk bars" based on the high annual number of alcohol-related arrests associated with them. Private clubs often used member volunteers as servers, and they were reluctant to restrict consumption or refuse service and saw their responsibility differently from servers in commercial establishments. The necessity for different training programs, incentives, and policy adoption approaches for each of the four groups of licensees required planning and preparation by trainers and managers.

The project was designed primarily as a research study that also delivered certain training and other services. As such, its objective was documentation of both process and outcome changes relative to impacts on targets. The problem of community ownership is more difficult in such research projects, because the objective then is not just to deliver services but to serve as change agents and to document change. Communities are generally interested in the services but lack interest or expertise in the research and evaluation aspects. The fact that the project included community leaders, servers, and the police in the planning process helped facilitate implementation. The fact that research results were presented to community leaders in the form of a slide show by project staff fostered understanding of the value of research and increased commitment to the research and data collection process.

The research element required a certain project structure, including a substantial centralized control provided by the integration of all supervisory functions under one project director. A less high-energy and productive work group could not have produced the volume of research and program activity in 4 years. While the cost was offset by project success and distinction, staff morale and potential burnout were a problem, when too many deadlines and too much pressure were perceived.

Finally, one of the most important and positive aspects of the project was the proximity of the Brown University Center for Alcohol and Addiction Studies, Butler Hospital and its distinguished research and evaluation team, and the illustrious Pawtucket Heart Health Project. The willingness of members of the advisory committee, composed of representatives of these organizations and of the alcohol prevention, treatment, and research community in Rhode Island, to serve as experts to the project was one of the most important ingredients in its success. This help contributed to the visibility, credibility, and innovativeness of the endeavor.

In conclusion, besides the suggestions made earlier, seven major recommendations emerge from the experience of this project:

- Funding bodies need to build in or allow for a planning period for innovative projects so problem formulation and detailing phases can be completed before decisions about final strategy must be made.
- The police and servers of alcoholic beverages are important groups to mobilize for preventing alcohol-related injuries, and the gatekeeper model of change agents is a useful way to conceptualize the process.
- A combination of education and regulation seems to be most acceptable. Server training was instituted before selective police enforcement of the dram shop law—server education preceded regulation—for greater acceptance among licensees and reinforcement of server training principles.
- A single community coordinator, who represents the project in the community, can serve as a facilitator, translating project goals to community leaders and community values and realities to project leaders. However, this position requires resisting pulls to be co-opted or to identify and ally with the community rather than the project. This situation is especially problematic if the project site is not located at the intervention site and requires a satellite office in the community staffed by the community coordinator.
- Community leaders need to be involved or to feel that they are involved in selecting effective and acceptable strategies and that their input matters. However, the locus of control must remain centralized with the project, at least as long as it is a research or demonstration project. This strategy requires delicate juggling.
- Funding needs to span an adequate period to allow for starting up; collecting and analyzing baseline data; developing, refining, and implementing interventions; and collecting sufficient followup data to measure outcomes adequately. Emphasis on gaining community financial support, volunteerism, and in-kind contribution is important, but project responsibility without control is untenable. Volunteers are never replacements for staff members, and programs rarely outlast their external funding sources when they originally are introduced from the outside.
- Interventions need to be tailored to the sociocultural, political, and economic environment of the community and must change with it. This fact raises issues of transferability and replicability of studies of this nature.

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Approaches and Agenda of Researchers or Evaluators Versus Those of Community Developers: Perspectives of the Program Developer, the Program Manager, and the Program Evaluator

Kathryn Graham, Sarah J. Saunders, and Margaret Flower

Background

In examining the different perspectives of evaluation, it is important to recognize at the outset that all evidence would suggest that program evaluation was invented by researchers and policymakers, and not by program staff who wanted "science" to tell them whether they were doing a good job. A related issue is the identification of what or who is actually being evaluated. Program evaluators generally maintain that they are evaluating the program and not the people delivering it. However, most programs are so loosely structured that differentiating the effectiveness of the program from the effectiveness of the staff is very difficult. Program evaluation can elicit great resistance because of the extent to which evaluators assume the role of judge of both the program and the people who implement it.

Another important consideration regarding program evaluation is its unique credibility as a type of research. The results of basic social science research are generally reported, criticized, reviewed, and possibly replicated but, ultimately, rarely affect people's lives to any extent. On the other hand, the negative findings of a single program evaluation may contribute to the elimination of that program or reduce the likelihood of its being adopted elsewhere. Although this occurrence generally does not happen (that is, most of the time program evaluation results, like those of basic research, are ignored), the potential impact of evaluation results is great. This impact is particularly frightening given the difficulties in conducting valid scientific research in real world settings. For example, what if the study was not sensitive enough to identify real effects? What if the wrong variables were studied? A potentially important (possibly lifesaving) program may be terminated because of an inadequately conceptualized or improperly conducted evaluation.

Given these considerations, program evaluation is unique research. Many considerations are involved other than those currently identified as part of the methodology of conducting basic research. One major requirement in conducting evaluations is a symbiotic relationship between the researchers and the programmers. To shed some light on how this symbiosis affects the conduct of evaluation research, this paper describes the evaluation of the Community Older Persons

Alcohol (COPA) Project from the perspectives of the program developer, the program manager, and the program evaluator.

This paper was initiated by the program evaluator because she believed that each of the other two contributors could provide a vivid reflection of her own perspective. An obvious bias exists in this joint presentation, however; it derives from a project where most differences have been resolved and describes perspectives that have partially merged over time—or at least have become more compatible. The paper does not necessarily represent the perspectives of parties involved in evaluation projects where differences have not been satisfactorily resolved. However, the project described here faltered so frequently and so seriously at times that the paper does provide information concerning the ways that different perspectives can influence the success or failure of an evaluation.

Our perspectives were not static during the project. Therefore what follows is a chronological description of the phases of the evaluation project and the three perspectives during each phase.

Preevaluation

Program Developer: In the late 1960s when I first started working in the field of addictions, the conclusion of the research literature was essentially that older people did not have alcohol problems. This view was partly based on the fact that very few people age 65 or older ever entered an alcoholism treatment program and consequently were not visible to those persons in the alcoholism treatment field.

Then, when I was invited to develop a treatment program for a group of actively drinking men, creating behavioral havoc in a large home for the aged, it seemed an interesting challenge but a rather low priority. Fortunately I had the time to respond. I was aware that Alcoholics Anonymous had been involved in the home for 18 months with all contact being totally refused by these residents. What evolved was a quasi-behavioral program that seemed to work after about 9 months—work in the sense that the behavior problems and frequency of intoxication dropped significantly (according to daily records of alcohol use and related behavior). Associated with this drop was a significant improvement in socializing skills and non-alcohol-related use of leisure time. At no time did the residents acknowledge a problem with their use of alcohol. This concept was important in developing future programs.

Over the next 8 years as this program was enlarged, I began receiving many requests from the community for assistance with elderly alcohol abusers. I noted that most of these requests came from home caregivers. Consequently I began making home visits with community health nurses to see if indeed there was a population of elderly alcoholics who were not being identified—there was!

Common themes that emerged were

- *most denied use of alcohol extensively, although alcohol problems were very obvious to other people.*
- *most refused to leave the home for almost any reason.*
- *many demonstrated problems related to alcohol use in every aspect of their lives.*
- *most totally resisted any suggestion of formal treatment for alcoholism.*
- *many identified needs that seemed quite different from those of younger alcoholics.*

What I learned from this experience was that given the opportunity to resolve some of their more socially acceptable problems (health, housing), helping them make the link between these problems and their use of alcohol was also often possible. We found that working with people on other problems often seemed to lead to their reducing their alcohol consumption, although total abstinence occurred in only a few people. However, even without total abstinence, the majority of those persons visited seemed to improve significantly in terms of living arrangements, health, and non-alcohol-related socializing and leisure activities, as well as reduced alcohol consumption. We also found that because of the multiplicity and variety of lifestyle problems experienced, many other agencies and services needed to be involved in the therapeutic process.

We seemed to have identified a hitherto unrecognized population of elderly alcohol abusers, and had developed a means whereby treatment was possible and apparently effective. By January 1981 I was receiving requests to develop a formal treatment program for elderly persons living in their own homes. A planning committee was formed that included representatives from all the major gerontological resources in Toronto, as well as the Addiction Research Foundation (ARF). The concept for the COPA program was developed in May 1981. When taking into account all the themes identified in the earlier project, the new program bore little resemblance to existing alcohol treatment programs either in the treatment goals, methodology, or program content.

In 1982 I began working with Gus Oki, an ARF staff member with considerable research experience. We identified the evaluation needs for the project, described in the project proposal presented to ARF before the project, as follows:

To collect data which will describe the outcome of the program by monitoring the following

- *client characteristics*
- *client referral patterns both into, and out of the proposed service*

- *extent and nature of the provision of primary care*
- *extent and nature of client contact with other agencies/services*
- *status of clients at regular intervals during the project and upon termination/discharge from the project.*

Even in my wiidest dreams, it never occurred to me how difficult it would be to even begin to answer these questions, and that 6 years later some of them would still be only somewhat answered and not because of lack of effort. When the Community Programs Evaluation Centre of ARF became involved, with great relief I dumped the evaluation component into Kate Graham's lap!

Program Evaluator: **Before the COPA Project, I had limited practical experience in conducting program evaluations, but a fair amount of theoretical knowledge. By theoretical standards, the COPA Project was not "evaluable." It had vague and ambitious objectives, even more vague implementation strategies, and numerous other problems from an evaluation perspective. Nevertheless the subject area was interesting and Sally Saunders, the program developer, was sincere and enthusiastic. Moreover this area was assigned to me as a research priority.**

Program Manager: ***When I started with the COPA Project in July 1983, the research component was under the tender loving care of Gus Oki. He had collected demographic material at the time that pinpointed Parkdale as a desirable test site. At the time we had been undertaking a 9-month project, and this timeframe dictated the boundaries of the research. Gus seemed to require basic numbers of age, sex, marital status, and so forth. He would supply the recording tools and I would fill them in. Research to me was simply "wouldn't it be interesting to know some of these statistics?" I certainly did not consider long-term effects (affecting either client or worker) or the intricacies of identifying collectable data, the effects of the complexities of the clients on the research today, the commitment required by the worker to the data collection.***

Setting Up the Evaluation

Program Developer: Even before the evaluation began, I had been invited to a 2-day workshop in Alberta where I presented the COPA concept. The presentation was well received and became a source of requests for other workshops. I believed that to continue these workshops, I was going to need a well-evaluated program that could be used as a model for developing other programs.

However, by this time I found that existing evaluation tools were simply not usable and consequently new ones would need to be designed. At the same time I was completely involved in the complexities of establishing this program and, *therefore, designing new forms was not my top priority. While recognizing the need for better instrumentation for assessing our target clients and evaluating their progress, I was more concerned with the actual day-to-day functioning of the program and willing to leave most of the instrumentation issues to the program evaluator.*

Program Evaluator: **After several preliminary meetings in early 1984 to establish roles and general directions for the project, the first priority was to develop instruments of data collection since existing instruments were not suitable. The purpose of the instruments to be developed was to provide valid measurement of the client's initial status in various life areas, especially alcohol and other drug use and problems at entry to treatment; the client's status on subsequent contacts; and, specifically, what was done with each client.**

Preliminary work included generating initial forms from existing case notes on clients and from discussions with program staff and analyzing assessment data already collected on 21 clients with existing assessment instrument. Based on this preliminary work, a proposal to begin the COPA Project evaluation was submitted to the ARF research secretariat. This proposal focused specifically on instrument development.

Program Manager: ***I saw no need for research and had no idea what being involved with research would entail. I had two main goals for the COPA Project: doing something for the clients, and getting public health nurses and other community caregivers to make referrals. I had very little experience and no model for addictions treatment (and therefore no bias). I had never heard of most of the standard addictions concepts or of methods for measuring these concepts.***

My main concern was client care. My safety net from researchers was that I could keep them away from the clients.

Pilot Work and Instrument Development

Program Developer: I soon realized that unless it was possible to capture the multiplicity of problems (many unique to the elderly), as well as the very complex, but pragmatic, nature of the treatment process, the approach to treating the elderly could not be passed on to others. Consequently I saw it as increasingly important that part of the research project be focused on devising a comprehensive assessment tool that had the potential to identify any and all possible problems among the target population.

At the same time a client contact form was being developed to document the nature of therapeutic interaction with the client and client progress in the various life areas. However, it appeared to me to be almost impossible to capture this *process using a formal evaluation instrument. I believed that while some of the general activities could be quantified, it was not possible to evaluate the spirit of the program that gave it life. I was quite pessimistic about the evaluation process at this time.*

Program Evaluator: **The heart of the research was to be the client contact form that would be used to monitor the client's status in various life areas, and actions taken by the worker to help the client. Developing this form seemed relatively straightforward and I assumed that an iterative process over several months would result in an objective data collection strategy that would be meaningful to the workers (because categories would be based on their open-ended responses and case notes). We also had a summer student who would spend part of her time accompanying workers on client visits so we could acquire some information on inter rater reliability of structured case notes.**

This time was fairly difficult in the evaluation. Margaret Flower, the program manager, made it clear that she was a reluctant partner in the research and at times demonstrated resistance by not completing forms until several weeks after the observer had been at the contact, thus reducing the validity of the data collection. I thought that I was bending over backward to make sure that the data collection was both sensitive and fair and was frustrated by this lack of compliance. At least once I telephoned Sally and threatened to stop the research if cooperation did not improve.

At the time we were developing the client contact form, work was being done to bring together a comprehensive assessment battery that would be appropriate specifically for elderly persons with alcohol or drug problems. This task was being done mostly at the request of the program developer, and not so much as a major part of the research (although some initial information was required for the research). The result was a 50-page assessment form that greatly increased my awareness of both the complexity of issues regarding alcohol and other drug use among the elderly and also the tremendous variability of clients seen by a program serving this population.

At this time I found it difficult to grasp exactly what the program was doing with clients, that is, what was the "program"? I also had some doubts as to whether some of the clients really had alcohol problems. In my analyses of the first 21 assessments (in which conventional techniques for reporting alcohol consumption and problems had been used), a great deal of data were missing in the alcohol section and half of those clients responding indicated that drinking was not a problem for them. In addition, according to the monitoring forms on many

clients, alcohol consumption and problems were rarely addressed during client contacts; rather, attention was focused on addressing and resolving the client's immediate problems that may or may not have been related to alcohol consumption. This practice seemed to me to be a very strange way to treat addictions where most of the clients appeared not to have alcohol or drug problems and where use of alcohol or drugs was rarely discussed. During this period I frequently phoned the case workers as I examined the reports. My concern was generally that a particular case did not seem to have an alcohol problem. Why then was the person in the program? The worker would then tell me about fairly severe alcohol-related problems that the client was experiencing. However, the worker would have obtained this information about alcohol problems from the community network, particularly visiting nurses, or from the worker's own observation of the client rather than the client's telling the worker directly. The initial assessment and monitoring forms had been based on conventional data collection strategies (i.e., self-report by the client) and did not provide sufficient opportunity for information from other sources to be recorded. As I became convinced that the program was, in fact, seeing people who had alcohol or other drug problems, the data collection instruments had to be modified to incorporate alternative sources of information.

Program Manager: ***The other counselor in the program liked the research component and even seemed to understand the process. Fine, I would fill out the forms when and if I had time and he could identify problems and suggest changes. I was busy with patients, policies, and procedures regarding the COPA Project.***

Next came the advent of Jadzia, a good-looking summer student, sent to collect data as part of the evaluation. Her job was to accompany us on client visits. I envisaged my elderly male clients dying of heart attacks in response to this young, attractive female. This situation gave me an added interest in the research. First, would some elderly gentleman die for love of Jadzia? Second, the observation aspect was really interesting. It was good to know that, at least some of the time, we were seen to be doing what we thought we were doing. No doubt a more experienced team would have had better data but what we did was least intrusive to clients and was done with honest enthusiasm.

Data Collection, Refinement, and Validation of Recording Procedures: First Results

Program Developer: As the need for refinement and validation of data collection procedures became apparent, Kate offered to make some home visits in order *to see exactly what was happening during client contacts. Her offer more than anything else gave me the sense that this research scientist was truly interested in developing as accurate an evaluation of the program as possible. The client contact form gradually evolved into a tool that captured most of the activities that occurred during an interview or home visit along with measures of the client's status in each life area.*

To begin to see the graphs of client changes in various life areas from visit to visit was exciting. I could identify when a major upset in one life area affected many other life areas at the same time, followed by an improvement in all with the resolution of the initial problem. These observations included changes and improvements in alcohol use and abuse—a useful demonstration of how alcohol problems are intertwined with other life problems. These hard data seemed to confirm and validate the program concept.

At this time it was also exciting to be able to use the research data to identify male-female differences in preparing for a presentation about the older woman substance abuser. The benefits of evaluation were beginning to show.

Program Evaluator: **I think my perspective during this period is best summed up by the number of method papers I wrote. A good indicator that a project is experiencing difficulties seems to be prolonged attention focused on methods rather than results!**

All kinds of problems arose in collecting and managing the data. Compliance was still less than ideal. The program staff were cooperative in spirit but paperwork tended to take low priority. While a source of frustration, this problem was by far not the only one and possibly not even the biggest. I made a lot of mistakes in setting up the monitoring forms so that the trial-and-error period of instrument development took a very long time—frustrating to all concerned. Collecting data on a sufficient number of cases for analyses took much longer than anticipated because the program was small and clients were often on the caseload for a long time.

As I began preliminary analyses, other problems emerged. First, difficulty existed in defining a case. Because many clients would not have voluntarily sought addictions treatment, the caseworker usually eased into the relationship by approaching the person's problem tactfully and slowly. It was not unusual for clients to be seen for two, three, or more visits and then reject the offer for counseling. Alternatively sometimes several contacts with the client were made to establish that the referral was inappropriate and the client did not have alcohol or drug problems. Obviously, in examining changes in the client during treatment, these instances (and they were quite frequent) had to be excluded. But often a judgment call was required to determine whether

the person was a treatment dropout (i.e., had received some treatment and should be in the analyses) or had never really entered treatment (i.e., should be excluded from analyses).

Problems also existed with some of the planned analyses. One of the major purposes of the data collection was to determine changes in the client's status regarding drinking, as well as other life areas, over the treatment process. The monitoring approach was chosen over a pretest/posttest approach largely because of the clients' age. Unfortunately the complexity of information gathered in this manner defied conventional statistical analyses. Interim reports were prepared during this period partly to provide feedback to the program staff but also to experiment with different methods of analysis. The quality of the data and the ultimate analyses were my greatest concern during this phase of the project.

Fortunately the data collection problems were only one side of the project. Other aspects, occurring concurrently, were both fun and exciting. Carol Birchmore Timney joined me on the research and we made client visits with the COPA Project workers to collect more interrater reliability data. These client visits had a considerable impact on my perspective on the research. First, the experience gave us a better understanding of the data collection process, including the frustrations of reducing complex human interactions to categories and numbers. Second, I lost all personal objectivity regarding the program. The program staff had impressive clinical skills. My subjective impression was that, whatever the data may show, the COPA Project workers were making life better for clients by providing empathy, caring, and practical help. Moreover, these "saintly" workers provided a lifeline for totally isolated people and, in some situations, even seemed to save lives! This circumstance increased my concern about the accuracy of the data. The research had to be sufficiently sensitive to identify important occurrences in the treatment process. The workers and I also became friends—a fact that increased my ability to twist their arms regarding compliance with the research but also increased their ability to resist my arm twisting. Our friendship was greatly improved by Carol's taking over most of the data coding (so that I was no longer continually reminded that compliance with data collection was not optimal).

By January 1986 we had become accustomed to working together. I had received some requests for data analyses or descriptions of other aspects of the research from the program. These requests helped to establish that the research was not simply a one-way street (i.e., their providing us with data). And, at this time, the project hired an extremely capable and intelligent secretary, who ensured that data collection occurred more reliably. With this closer working relationship and the growing bank of information on the program, we decided to prepare a symposium on the COPA Project (combining the research and the clinical experience).

Our symposium was presented at the annual meeting of the Canadian Association on Gerontology in November 1986. During this phase of the research, the seed for a research project using a case study approach was planted. In fall 1986 the program staff and I jointly submitted a proposal to conduct case study analyses using existing client files supplemented by client interviews. This additional project received funding in January 1988. At this point we began to work more as a team and less from competing perspectives.

Program Manager: Somewhere in all of this we also had "home visits with Kate and Carol," which we thought were a riot but also very significant. The visits gave value to our work and our clients. The researchers were willing to see the situation from our perspective, which, for me, meant that clients were real and not just data. We also met with the researchers more frequently and they were able to clarify why different aspects of the research were being done and what their needs were. I no longer felt we were collecting material in a vacuum. I had a vague understanding of the research and became willing to help—but research was still not my priority!

Then we went to Quebec to present our symposium, which was my first major presentation and the first major presentation describing the COPA Project in conjunction with our scientist. I was able to see a client transferred to graphs and recognize the pattern—it was very exciting! The reality was, although I had participated in the symposium, I was still unable to see where the research fit into my day-to-day work. (That is, I did not phone and say "We have a problem with 093, could you send a profile? We might be able to identify a pattern, or problematic times, or even recurring emotional low points.") All sorts of possibilities and applications may have been missed. However, all of us were learning, meeting new commitments and expectations, and feeling our way around.

The final version of the assessment form emerged during this period and was very impressive. But, to me it was still a research tool, with no great value in assessing the client. It was useful for "showing off" to other health care professionals when talking about the COPA Project and our wonderful work. I did recognize how assessment pertained to the data collection forms, and for 1 whole minute considered suggesting a reassessment when the client was discharged. Heaven forbid! Regardless of my good intentions,

Kate's persuasive entreaties, and the obligations one feels toward one's colleagues, research was still not a priority.

I was often confused and frustrated about defining when a person should be considered a client, where families fit in, how valid the information was, whether we were collecting enough data for a viable study, and about the guilt—how many possible pieces of data had been screwed up through incompletion of forms, not to mention time lapse. I think one problem was that the assessments were filled in and then never looked at again by COPA Project staff—partly because we were so involved with the clients and partly because we had narrative notes to which to refer.

What did develop for me, however, was the value of the assessment as a teaching tool. The assessment provided students with a format—probably the only thing at the COPA Project that was black and white. The assessment form also helped pinpoint the exact information gained, thus highlighting areas that needed to be further explored. Finally the assessment form was a good motivator for the worker—a measure, if you will, of the progress made in getting to know a client over three visits. The enthusiasm with which I currently "sell" the assessment form indicates how much I have come to value it.

Data Collection: Final Phase

Program Developer: In the final phase of data collection the final contact form was also completed. The form turned out to be an excellent teaching tool as well as research form. Although the process took years, developing the form provided valuable information to us about the program in that the data collection approach was modified repeatedly to capture the essence of the methodology and content of the COPA Program, as opposed to other chemical dependency programs. The developmental process was at least as important to me as the actual end result. It demonstrated to me, as a clinician and community developer, that a research scientist could be a caring, understanding person who really wanted to identify the human complexities and processes of an innovative treatment program. There, I have just given away my stereotype of a research scientist! The assessment tool, while very large and cumbersome, has been invaluable in identifying all possible problem areas, and remains a useful teaching tool. Again the process of development of the assessment battery was almost more valuable than the end result. That process forced us repeatedly to clarify our thinking and our questions in assessing the immediate and long-term needs of the clients.

Program Evaluator: **During the final phase of data collection, research and program perspectives concerning the evaluation seemed to merge,**

and a more collegial relationship developed between the research staff and the program staff. The data collection was proceeding relatively smoothly. In addition the program manager and the program developer began to make greater use of the data base, asking for specific analyses for reports and proposals that were being prepared.

Program Manager: ***During this phase, preliminary analyses of actions taken by the workers during the client contacts were presented at a conference. What a reaffirmation of faith in the worker, what positive reinforcement. I incorporated the worker action descriptions as a teaching tool for third-year social work students to help them identify what it is they are doing, and how they can repeat successful interventions.***

Final Report: Case Studies, Next Step?

Program Developer: As the evaluation project drew to a close, we discovered we had just begun to evaluate the COPA Program. The research had identified the need for descriptive case studies. Until this spinoff study, little information was available describing the older alcohol abuser. Similarly, the COPA Program had been making heavy use of other services and agencies, an issue which had not yet been addressed by the research.

Interest in the COPA model was being expressed not only nationally but internationally. This interest underscored the need to continue the process of identifying what we were doing, who were our clientele, and what was the outcome in order to present an increasingly refined version of the COPA model to others.

Program Evaluator: **The end of data collection was set at December 31, 1987. Four or five months were needed to code, enter, and clean up the data; track down missing assessments; identify cases; and generally bring the enormous data base into some kind of order. My primary concerns were data reduction and analyses and organizing all the information into a final report.**

Concurrently we began the case study analyses. Anne Zeidman, who had interned at the COPA Project, was hired on the project and did most of the basic work—compiling case histories and making followup calls. Although the objectives of the case studies were similar to those of the quantitative evaluation research, the different approach allowed for a much greater collaboration between clinician and researcher. The case study research turned out to be one of the most interesting aspects of the project for me.

Finally, as the research came to a close, we all seemed to think of future research at the COPA Project. Back in 1984 through 1986, I would

have found it hard to believe that I would be willing to reenlist for more research with this program and even harder to believe that they would volunteer for additional research! However, alcohol abuse among the elderly turned out to be a very interesting subject. And, as often happens, the research had raised more questions than it had answered. Finally I could not imagine no longer working with the COPA Project. So we have planned a maintenance research diet for 1989—a modest amount of data collection—continuing to look at some old questions (e.g., what happens to the clients in the program?). But we will add some new questions on the advocacy/coordination roles with other agencies that form part of the services to clients.

Program Manager: ***The following sums up my perspective regarding the evaluation and how I came to my current outlook:***

- ***I saw no great need for research.***
- ***I did it but without interest.***
- ***With time and feedback, I gained minimal insight.***
- ***As results came in I saw the value of the work.***
- ***When I started to use it as a teaching tool, then I became enthused.***
- ***It took me several months to discard unused data collection forms after the data collection had stopped!***

Conclusions

Not all evaluations take the form of the COPA Project. Evaluations based on pre- and posttreatment data collected by research staff usually would not involve the program staff to such a great extent. However, with increasing focus on process (i.e., if it worked you need to know what it was you did) and on expanding the nature of evaluation questions, the mutual dependencies described in the COPA Project evaluation are common in many evaluation projects.

Examining our differing perspectives, four themes seem to emerge: trust, priorities, communication, and reward.

Trust

There are two sides to the issue of trust: self-trust and trust of others involved in the evaluation. From the program developer's perspective, trust seems to be captured by the following questions:

- Do I really believe in this program?

- Do I trust the program staff to implement the program as I have conceived it?
- Do I trust that the evaluator will fairly evaluate my program?

From the evaluator's perspective:

- Do I really believe that this program is worth evaluating?
- Do I trust the program staff to be accurate in their reporting?
- Do I believe that I will be able to do a good job evaluating this program?

From the program manager's perspective:

- Do I believe in this program concept?
- Do I believe that I am doing a good job?
- Do I trust that the evaluator will fairly evaluate my work?

Trust seems to be a necessary part of evaluation research. At a minimum the program staff must trust the evaluator. Evaluation is not an objective science. The reality is that the program is at the mercy of the evaluator who chooses what information to collect and how to collect it. Usually the evaluator also has to trust the program staff. For the researcher-evaluator (as opposed to the administrator-evaluator), professional rewards are gained by evaluating good programs (not identifying bad ones). Failing to reject the null hypothesis is the least desirable outcome from a scientific perspective. Therefore the evaluator has a stake in trusting that the program is a good one, and that the research will consist of identifying how good the program is, in what ways it works, and so forth.

Priorities

Our experience with the COPA Project suggests that, in the day-to-day conduct of evaluations where program staff are part of the data collection process, priorities are the biggest source of conflict. The program staff rightly placed highest priority on their service to their clients. But, a lot of other aspects of the job were more attractive than research paperwork, and the evaluator had to fight for second priority. The evaluator's top priority was clean, complete, and valid data because the worth of the data would affect the worth of the results of the ultimate data analysis.

The program staff were oriented to the present (e.g., immediate needs of the clients), and particularly, because this was a first evaluation, considerations of data analysis for the future did not have a big impact on compliance with the research. The program developer was able to exert some pressure, but the most important factor that raised the priority of research was for the program staff to see and use some of the results. Similarly the priority of the research became higher for the program staff when the evaluator was able to reduce some data collection demands by experiencing the program and the burden of the data collection by accompanying the worker on client visits.

Communication

One source of poor communication in the evaluation process is the differential training of the program staff and the program evaluator. Clinicians are usually trained in positive regard; evaluators presumably in critical thinking. These differences in orientation produce immediate differences in language and thinking. In addition, the evaluator may have a poor understanding of the clinical experience and how this will affect the data collection. Similarly, the clinician may have little knowledge of research and the relationship between rigorous data collection and valid results. Our experience suggests that all parties underestimated the need to communicate with one another. Because the evaluator lived 200 kilometers from the program, there was little opportunity for incidental or casual communication. Until the evaluator spent more time with the program and the program manager, she could not identify the best ways of collecting data. Similarly, as later observed by the program manager, cooperation improved when program staff were able to understand what the research was about. Dummy tables, hypothetical graphs, and more discussion earlier in the project might have aided this understanding and accelerated the evaluation process.

Rewards

Evaluators frequently promise program staff that the information collected as part of the research will be useful to them for program improvement. Our experience suggested that this is only partly true. From the *program developer's* perspective, the evaluation process was rewarding. It helped her to clarify, elaborate, and adjust the original program concept. However, the *program manager* did not find that feedback from the evaluation was *directly useful for clinical purposes* (i.e., the actual treatment of clients). How the evaluation proved rewarding for the program manager (as well as for the program developer) was in improving the description of both the program and the target population. The evaluation procedures were also found useful as tools for training new staff and student interns. The program manager's dedication to the research increased greatly by her being able to use some of the results. Because the COPA Program is small, frontline staff were also involved in using the research. However, given the lack of impact on clinical practices, had the frontline workers not been involved in training and community presentations, the evaluation would have provided little reinforcement for their data collection efforts. Although interim reports and case analyses were prepared, these were never reproduced in sufficient time to be immediately useful for the frontline workers. The compliance with data collection and the validity of the reports might have been enhanced by data collection procedures that allowed for immediate feedback in the form of client progress graphs, frequencies of events, and the like. It is apparent that the perspective of the frontline worker is different from that of the program manager and would have added a distinct fourth dimension had it been included in this paper.

We learned a great deal during this evaluation. We also learned a lot by writing this paper and putting our perspectives into words. Too often the evaluation perspectives are described solely by evaluators (based on their understanding of each perspective). We hope that by having each of us describe her perspective about the evaluation process, recognition of the issues that we have raised can contribute to improved methodology in evaluation research generally.

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Aftermath of the Community Action Project on Alcohol: Integration or Attrition?

Sally Casswell and Liz Stewart

Background of the Campaign

The history of alcohol use in New Zealand mirrors that of many industrialized nations during the 20th century. A posttemperance liberalization of access to alcoholic beverages, an increase in alcohol consumption, and increased admissions to hospital for alcoholism have produced considerable public concern. In response to this concern, a statutory body, the Alcoholic Liquor Advisory Council (ALAC), was set up in 1976 to advise the Government on alcohol use. ALAC, funded by a levy on alcohol sales, assumed responsibility for research on and prevention of alcohol-related problems, as well as the funding of treatment services.

In conjunction with a medical funding agency, ALAC established the Alcohol Research Unit (ARU), which has a major focus on primary prevention. Encouraged by the examples of community-based, heart-disease-prevention projects carried out in the 1970s in California (Farquhar et al. 1977) and New South Wales (Egger et al. 1979), and interested in strategies for evaluating primary prevention efforts, the ARU proposed to carry out a major quasi-experimental project, with a focus on alcohol issues.

This paper describes the nature of the ARU's community organization program and briefly outlines the evaluation strategies used to assess it. The results of the outcome evaluation have been reported elsewhere (Casswell and Gilmore, 1989; Casswell, Gilmore et al. 1989) and are only summarized here. The focus of this chapter is on the aftermath of the project, particularly which elements of the demonstration program were used in the followup work of the central funding agency. The data sources used here include discussions with ALAC staff members; participant observation, facilitated by ARU's continuing input into developmental research and process evaluation of ALAC's activities; published reports; and media coverage.

The Community Action Program

The Community Action Project (CAP) took place from October 1982 to March 1985. It included a paid mass-media campaign and a community organization program. A quasi-experimental design was employed in which two cities served as reference cities, four cities were exposed to the mass-media campaign, and two of the four also participated in a community organization program. Details of the selection of cities were given in Casswell and Gilmore (1989). The program differed from previous community-based projects in both the alcohol (Wallack and Barrows 1981) and heart-disease-prevention areas (Egger et al. 1979; Farquhar et al. 1977; McAlister et al. 1982) in that its objectives included a major focus on policy issues. The individual objectives for the program included an increase in support among the general public for relevant public policies, as well as the more usual objective of reinforcement of attitudes and behavior supportive of moderation in alcohol use. At the community level, the objectives included achieving an increase in the amount of material about moderation and alcohol-policy issues in the local print media. The program also aimed at increasing appropriate alcohol-related behavior on the part of local organizations, especially the development of alcohol policies by organizations such as city councils and hospital boards.

Administrative Structure

In the two cities that participated in the community organization program, a local person was recruited to fill the role of community organizer and was employed on a full-time basis, with funds from ALAC. Because the focus of the organizers' work was at the community level rather than directed at change in individual behavior and attitudes, the administrative base from which the organizers worked had to be supportive of community organization aims. Office space and administrative and secretarial services were therefore established in tertiary community education settings (community colleges). Both organizers believed such venues were integral to their ability to work effectively because the other staff who were familiar with community organization aims provided ongoing support for that approach. The project staff felt that alcohol treatment agencies were not appropriate locations for the organizers because of their primary focus on the individual client and on alcohol-related problems at a tertiary rather than primary prevention level. Because of the limited timeframe of the demonstration project, the organizers did not extend the approach of the treatment agencies to include an emphasis on policy. However, the organizers found that interaction with treatment personnel was essential.

A second important aspect of the administrative structure was the meeting held every 2 to 3 months between the two organizers and project staff from ALAC and ARU. At these meetings, the organizers were encouraged to work with community organizations at a structural level, rather than with individuals. Project staff attempted to maintain the emphasis on policy issues while recognizing the organizers' primary allegiance to the local community and its need for work with individuals. Meetings often served as forums for vigorous debates, including the feasibility of implementing suggested programs in the community setting.

A third level of support for the community organizer came from the local community councils on alcohol, which primarily comprised social service and treatment facility personnel. A principal role of these organizations was to establish task-oriented groups to work on a range of issues. Both organizers became spokespeople for their local community councils. Much work undertaken by the community organizers was done in the name of these organizations.

Policy Focus

A major objective of the community organizers' work was to increase the level of support for healthy public policies at the individual level. At the community level, the program aimed at increasing appropriate community organizational responses and media coverage of alcohol policy issues. At a policy level, the program primarily was concerned with influencing policy regarding the availability and the advertising of alcohol products. The price of alcoholic beverages—another focus of the project's policy program—received less attention partly because it was seen as a nationally determined issue, and thus beyond any local influence.

One approach to reducing the availability of alcohol was to respond to alcohol-licensing initiatives as they went to local authorities. For the organizers, to undertake action on applications for new liquor licenses in the two cities was a particularly appropriate medium through which to publicize the issues of alcohol control. Also, such actions provided concrete opportunities to work at restricting the availability of alcohol. Organizers made submissions to the licensing authority, and they provided information and resources to resident groups that objected to particular licenses. Often liquor license applications were used as opportunities to publicize the broader issues of alcohol-control policy rather than simply to object to a specific case.

In efforts to alter drinking behavior on licensed premises, the organizers took two major approaches: contact with the police, as the major law enforcement agency; and contact with trade representatives regarding bar server training. Each approach illustrated difficulties typical of such public health, community organization work: There was resistance to change stemming from commercial vested interests and acceptance of relatively heavy levels of alcohol use.

A significant aspect of the community organizers' work was liaison with the local city councils to advocate that the council take an active role in the prevention of alcohol problems. In one city, the community organizer made a presentation to the city council, outlining the potential of the council to reduce alcohol problems. The community organizer described two strategies by which the council could reduce alcohol problems. One emphasized the need for the councilors to act as community leaders and to recognize their ability to shape local public opinion, which in turn could influence national policy on alcohol issues. The second strategy was for the council to use its specific powers over leases and bylaws to control the sale of alcohol. The community organizer's presentation was well received, and he was asked to prepare a draft policy on alcohol control. Although initial reaction to the draft policy was enthusiastic and meetings continued with councilors and administrative staff, resistance was soon encountered over some elements of the draft policy. For example, some members of the Council expressed concern for the financial future of licensed sports clubs (many of which leased clubrooms on council-owned land) because these clubs gained considerable revenue from alcohol sales.

Promotion of Healthy Living

The organizers initiated other activities to promote healthy living. These included organizing nonalcoholic cocktail competitions and pub crawls; publishing pamphlets with recipes for nonalcoholic drinks; and organizing community fun days or special theme weeks that emphasized alternative activities to drinking alcohol. The organizers asked manufacturers of fruit juices to provide promotional materials and samples for these activities. In one city, licensees and staff from all local licensed outlets were invited to a promotion of nonalcoholic products. Lack of interest, however, forced the promotion to be cancelled, leading the community organizer to conclude that there was considerable resistance or apathy from the licensed trade and sports club administrations toward promoting nonalcoholic drinks.

The organizers also approached local sports associations with sponsorship proposals. In one case, although the local cricket association initially expressed interest in the idea of a major coaching clinic and match, enthusiasm for the endeavor waned when it was determined that having the community council's name attached as sponsor was not attractive. The idea was dropped. In the other city, negotiations with a major fruit juice producer to sponsor a cricket project also eventually fell through, despite enthusiasm from the cricket authorities. Ironically, the cricket association then concluded an arrangement with a major brewer. This instance, as well as others, made it apparent that local alcoholic beverage interests were quick to take up sponsorship proposals declined by other businesses. Thus, it became clear that negotiating sponsorship arrangements was another area where considerably more effort and resources than were available to the project would be necessary if there was to be any chance of altering existing patterns of sponsorship.

Seizing the Opportunity—Using Controversy and Publicity

A major objective of the CAP program was to increase the amount of alcohol-policy-related material (excluding industry promotions) in the local media. A key media strategy was using controversy to highlight alcohol issues within the community.

Establishing receptive contacts within the local print and radio media helped the community organizers gain coverage of events, although the relationship between the community organizers and their media contacts at times proved to be fragile. For instance, after one organizer's reporter contact left the newspaper, the organizer noted a distinct editorial resistance toward using her press releases—which had previously been accepted. In the early days of the project, most of the media successes occurred when the organizers actively exploited opportunities that arose in their community. However, by the end of the 3-year project, the community workers did not always have to take the initiative: local journalists approached the organizers for comments.

Mass-Media Campaign

The paid mass-media campaign used in the program focused primarily on the traditional target of drinking by young males, in an attempt to change the social climate in favor of moderation. The media employed were radio, films, and—most often—television.

An attempt to link the mass-media and community organization components of the program was made. The organizers distributed print resources that were clearly linked with the campaign; and the workers also were involved in the radio advertising of a sponsored rock concert and an associated competition. Despite the choice of a campaign target group that had obvious face validity, the campaign nevertheless produced some controversy. The ALAC chairman withdrew a commercial from broadcast on the grounds that it promoted permissiveness. The commercial had been shown for 10 months before its abrupt withdrawal, and there was considerable public outcry over the decision. This controversy was managed by project staff to increase publicity for the health-promotion message (Casswell, Ransom et al. in press).

The Evaluation and Its Findings

A range of evaluation strategies was used to assess the CAP program. Considerable emphasis was placed on documenting the process of the program, using participant observation, interviews, and written reports. Survey data were collected to assess the impact of the mass-media campaign. The outcome of the project was evaluated using longitudinal indepth interviews with a small number of key informants in the community organization cities, by monitoring coverage of alcohol issues in the local print media and by conducting surveys before and after the project with independent random samples drawn from each of the six participating cities.

The evaluation findings have been fully documented elsewhere. In brief, the process evaluation documented the feasibility of using a community organization approach to generate discussion and action concerning issues of alcohol policy (Casswell and Stewart 1989). The mass-media campaign's appeal to the target group and the extent of community support for the approach taken also were documented (Casswell, Ransom et al. in press). Both the longitudinal and the before-and-after surveys suggested some positive outcomes of the program (both mass-media and community organization) regarding support for alcohol policies (Casswell, Gilmore et al. 1989). In the community organization cities, attitudes toward alcohol use had also shifted appropriately (Casswell and Gilmore, 1989).

The Aftermath

During the course of the CAP program, the major channels of communication between the project and the major funding agency, ALAC, were not directly with ALAC itself, but with two committees set up to advise the council. The evaluation strategies were scrutinized by a research committee and funded on its recommendation. The program was similarly overseen by an education/prevention committee. Members of both committees felt a reasonable degree of ownership of the demonstration project. For example, during the major controversy over the mass-media campaign, members of both committees expressed their concern over the ALAC chairman's action. This expression of concern was particularly strong in the case of the education/prevention committee.

In March 1985, following the end of the experimental project, ALAC made a decision (on the recommendation of the education/prevention committee) to continue funding the two existing community organizers and to expand the project to include four more staff positions in different locations. The mass-media campaign was also continued; in fact, it was expanded to a national campaign. These decisions were based on the results of the process evaluations, which clearly demonstrated the feasibility of the CAP approach to both community organization and mass-media campaigns. (The evaluation results were not available until well after this decision was taken.)

Support for continuation of the community action approach came not only from the central funding agency, ALAC, but also—and perhaps more significantly—from the two participating communities themselves. The two staff positions, previously fully funded by ALAC, were continued, but with two-thirds of the funding coming from the host educational institutions and the local health authority. In one of the cities, the community worker's base became a more independent one, a community initiative called Health Action.

In March 1985, however, the same month in which the decision was made to continue funding the community action workers, the chairperson of ALAC was replaced, signaling the beginning of a period of major redirection for the organization. The new chairperson commissioned a review of ALAC's administration and structure. The subsequent report, published in June 1986, suggested that the committees had assumed functions beyond their advisory roles and that many issues that came before the committees were the result of their own initiatives. The report recommended the abolition of the committees (except for the research committee)—a step that was implemented shortly thereafter. This change had the effect of reducing direct community input into ALAC's program development and put much more responsibility on the professional staff.

The increase in the number of ALAC-funded community workers had been accompanied by the appointment to the professional staff of a health-promotion advisor charged with the administration and support of the community workers. The original staff member who had worked closely with ARU project staff on the CAP program continued to work in the area of mass-media programs for several months after the completion of the CAP program before taking leave and subsequently resigning from the position in late 1987. The influx of new staff, accompanied by the departure of a key staff member, negatively affected the continuity of experience from CAP to the subsequent program. Moreover, input from research project staff seemed to wane in the subsequent program, although one meeting was held in December 1986 between the community workers and the director of the ARU at which the philosophy and approach of CAP were discussed.

The ARU conducted a very small process evaluation of the community workers scheme as it evolved after the end of the CAP program. (No impact evaluation was carried out.) The process evaluation was based on attendance at nine meetings held between the ALAC health-promotion advisor and the community workers and an analysis of quarterly reports written specifically for the evaluation by the community workers between early 1986 and the end of 1987. These data sources suggested a significant level of discontent and dysfunction within the program. The workers apparently perceived a lack of practical support from ALAC and confusion over the way in which they should translate their objectives into implementation strategies. During the 18 months covered by the process evaluation, the community workers clearly received insufficient orientation and ongoing training in community-based health promotion. Difficult issues remained, such as the need to balance the communities' desire for face-to-face education with community organization and policy-oriented activity.

On the part of ALAC, there was considerable unresolved concern over the accountability of the community workers. Although liaison meetings were held, much of the meeting time was taken up with discussion of administrative details and the appropriateness of expenditures of the community workers' small promotional budgets, leaving little time for planning and evaluating the translation of program objectives into community initiatives.

The health-promotion advisor left his position after 18 months and was succeeded by one of the community workers (who was also one of the two original CAP workers). However, under this new advisor, there has not been an increase in input to the workers. ALAC's current policy is that the funding of community workers is a seeding scheme; it is hoped that newly established regional health authorities will take over both complete funding and administration of the positions.

The mass-media campaign has also changed markedly since the end of the CAP project. A new television commercial aimed at the young male target group and developed after considerable research and formative evaluation was rejected by Television New Zealand on the grounds of bad taste. After private negotiations, the commercial was allowed to air after 9 p.m. This time slot effectively excluded it from being shown during much sports programming when alcohol industry sponsorship of sports events and teams was advertised. Although the refusal to screen the commercial provided the potential for considerable controversy and publicity, this opportunity was not exploited. Subsequently there has been a move away from broadcast advertising and into a print campaign using a less controversial problem-amplification approach. There is currently no apparent link between the mass-media campaign and the community workers.

The Political and Social Context of the Aftermath

These shifts in organizational direction have taken place in the context of considerable political and social change. The Government in power in New Zealand from 1975 to 1984, which passed the legislation establishing ALAC and contributed to the climate of opinion in which CAP took place, was relatively interventionist in economic and social terms. Alcohol taxes were increased regularly between 1977 and 1981; the justification for such increases was the high cost of alcohol problems for public health and social welfare services. (Taxes were also increased during the time of the CAP program, but the real price of alcohol stayed about the same.)

In 1984, a new Government, which espoused a much more free market and deregulation ideology, came to power in New Zealand. Soon after the end of the CAP program, there was evidence of direct pressure on ALAC. This was heralded by statements made by a government member of parliament (MP) and first publicized in the print media in April 1986. Speaking at a meeting convened to establish a community alcohol-awareness group, the MP criticized community groups for antialcohol bias, commenting that their emphasis was always on the negative aspects of excessive alcohol use rather than the advantages of the beneficial use of alcohol (*Evening Post*, 1986). The *Post* stated:

> It was extraordinary, he said, that there were still people advocating an anti-alcohol strategy that attacked the drinking patterns of a whole society to prevent the drinking problems of a few. However academically sound the theory might be, it is simply not going to appeal to New Zealanders as a whole and is therefore doomed to disaster from the outset.

The MP went on to explicitly criticize ALAC for its relationship with community groups:

> Given its association with some of the extremist groups ALAC is presently making it difficult for Parliament to use it effectively in this primary [advisory] role (*Evening Post*, 1986).

Further media coverage critical of ALAC was published during the next few months: "Big questions hang over how well ALAC does its expensive job" (*Auckland Star*, May 22, 1986), and the same MP (whose criticisms were said to carry considerable weight because he was a former employee of ALAC) repeated his public statements (*Dominion*, 1986).

This criticism took place in the context of a more general "great quango hunt" in which about 40 publicly funded bodies were eliminated (*Auckland Star*, April 10, 1986). However, criticism of ALAC was more specific; and it is likely that liquor industry opinions were a factor (*Auckland Star*, May 22, 1986). For example, during this period, a big-business lobby group was established in which a major alcohol industrialist played a key role. The establishment of such a group likely provided numerous opportunities for input to Government.

It seems very likely that during the first months after the completion of the demonstration project, ALAC, the council of which now comprised an all-new membership, was clearly aware of considerable critical scrutiny from Government and liquor industry sources.

Discussion

The decrease in apparent organizational commitment to the CAP-type community organization program in the years following the end of the experimental program can partly be explained by changes in the social and political climate. Criticism of the approach taken by CAP began during its implementation, but intensified in the months following its completion. The increase in public (and probably private) opposition to ALAC's role in this policy-related community action was probably a response to the high profile achieved by the CAP program and also more general ideological shifts.

The lack of organizational commitment to the community organization component of the program was reflected in a high level of dissatisfaction on the part of the community workers. Although the funding of the community positions has remained higher than that during the demonstration project (because of the increased number of positions), the input to the workers has declined. Not only are there fewer regular meetings (currently three meetings per year, rather than the six during CAP), but also there is less organizational support provided for the workers to ensure that a policy orientation on alcohol issues is adopted. A considerable part of the CAP effort was directed toward providing the community organizers with policy-relevant information and an opportunity to debate the most appropriate way to address policy issues in their community context. The differences between the demands of their host communities and the demands of the central funding agency were given adequate airing.

This decline in both informational and motivational resource input is one of the most significant shifts that has occurred in the aftermath of CAP. There is a need for appropriate levels of support and resources from the central funding agency, which often has access to information, both published and unpublished, which the community does not.

Wakefield and Wilson (1986, p. 449) have drawn attention to the crucial importance of the relationship between the central funding agencies and the community:

> Therefore, one of the practical challenges in planning and implementing large scale programs lies in the extent to which central health authorities and community organizations can work co-operatively in pursuit of common goals.

Wakefield and Wilson were concerned primarily with the level of community participation in planning and decisionmaking. Their review of large-scale public health education programs suggested that program success relied heavily on the involvement and influence of community organizations. When ALAC reduced its input to the community organization program, there was no effective protest from the community organizations themselves, suggesting that the demonstration project had failed to adequately involve and shift ownership of the program to the community. On the other hand, the nature of the reduced input was more difficult to perceive and criticize than, for example, a cessation of funding would have been. Thus, the lack of public outcry was understandable.

The aftermath of CAP was also influenced by the structural changes imposed on the ALAC organization and by personnel changes. Such changes contribute to the difficulties faced by even large-scale and expensive evaluation exercises such as this one in ensuring that the experiences gained and documented in fact contribute to the funding organization's subsequent policy and programs (Greenberg and Robins 1985). Much has been written about the difficulties of communicating research findings so that they are useful and relevant for policymakers. CAP's difficulties were probably no exception. A resource kit developed after the program's completion disseminated the nature of the program and publicized its feasibility in a relatively accessible form, especially when compared with the availability of academic journal articles (Alcohol Research Unit 1985). However, the decline in face-to-face contact between ARU project staff and ALAC personnel hindered this dissemination. The changed political climate contributed to this decline, and ARU's previous role in relation to the community programs was being roundly criticized. The situation was likely exacerbated by the exhaustion of project staff—fairly typical following the completion of major demonstration projects.

Despite the constraints under which the community workers have been operating and their somewhat uncertain future, these ALAC-funded positions still exist. The positions are unique within New Zealand health promotion; no other centrally funded workers have such a clear mandate to use the strategies of community organization and media advocacy. (However, the recent establishment of regional authorities with statutory responsibility for health promotion, as well as health services, has again changed the climate in which the community workers operate; it is possible that the CAP initiative will be assimilated into an institutional health model.)

The CAP program illustrated the feasibility of a community organization approach to alcohol prevention within a quasi-experimental context. The aftermath of CAP has illustrated the significant role played by the informational and motivational resources provided by the central funding agency and suggests the extent to which this input is vulnerable to changes in political and organizational climates.

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CHAPTER 5

Prevention Settings and Opportunities

Addressing the Problems of Action Research in the Community: Lessons from Alcohol and Drug Education

Michael S. Goodstadt

Prevention efforts in all health areas have increasingly been focused on the community. This reorientation has a number of historical and conceptual roots. Among the historical factors is a growing tradition of large-scale, community-based research programs that have their origin in the Stanford Heart Disease Prevention Program's three-communities study (e.g., Green et al. 1984; Farquhar et al. 1985). At the conceptual level the role of the community has been better appreciated as an active agent of change, rather than as merely the passive recipient of change. Among the most explicit expressions of this shift is the emphasis on the community in the development and implementation of school-based prevention programs, and the development of the concept of community empowerment within the health-promotion movement (e.g., Wallerstein and Bernstein 1988). It should, however, be recognized that the community, in one form or another, has been the setting for most prevention programming and research, and that lessons are to be learned from these earlier experiences regarding the advantages and disadvantages of developing, implementing, and evaluating prevention strategies in community settings.

This paper will focus, in particular, on the limitations imposed by and on community-based research. The problems arising from conflicting community and research agendas will be considered; examples will be used from one researcher's experiences to highlight the nature of these conflicts, providing a public confession of those research failures that arose from the community context of his research; and, finally, suggestions will be offered concerning how congruity between the community's and the researcher's agendas can be maximized.

The term community can refer to the collectivity of individuals as defined by geographical or psychological space, or representatives of that collectivity as defined by their formal (i.e., administrative or elected) or informal leadership positions in their community. Unless otherwise stated, references to community in this paper imply the wishes of the collectivity as expressed by its elected or appointed representatives.

Conflicting Goals: Knowledge Versus Programs and Services

The first and most fundamental source of conflict between researchers and the community is evident when one attempts to define the overall goal of the enterprise. Although researchers and the community may share common goals, their goals are distinguishable on the basis of their response to the question, "What do you feel is an essential product of your efforts?" Ultimately researchers are attempting to expand the body of knowledge concerning prevention efforts. The focus of their activities, and the resulting knowledge, may lie at different levels including the media of influence and change, the processes of implementing change, the underlying dynamics of change, and the outcome and impact of the change strategies. In each case, however, the researcher is more concerned with advancing understanding than with developing or implementing a prevention strategy. In contrast the community is more often preoccupied with developing and/or implementing a service or program. Even in those instances in which the community claims to be concerned with improving programs or services, its bottom line is the existence of a program or service regardless of research findings.

The impact of the community's product-oriented focus may be felt early in contact with the researcher and can also be documented, post hoc, as existing before the contact. Community-researcher collaboration, on the surface, may be the result of overtures either from the community or from the researcher. In reality consent from the community is forthcoming only when it perceives that its own needs will be met as a result. For example, I approached the health education administrators of a very large Ontario school board with a proposal to modify and/or improve and evaluate the impact of an alcohol and drug curriculum that had been used by the school board and many imitators for nearly 10 years. (Unless otherwise stated, in this paper, "drug(s)" refers to alcohol, tobacco, illicit, and other drugs.) This overture was rejected. One year later the same administrator approached me with essentially the same proposal. The critical intervening event was the complaint by two prominent community members to elected school board members about the growing problem of alcohol use among young people in the community. The school board, as a result, directed the health education administrators to suggest improvements to the curriculum; the health education coordinator, in turn, requested my assistance in the task. As a result of these demands and the associated legitimization of the health education coordinator's efforts to improve the quality of alcohol education, the health education coordinator, my research staff and I were able to devote 4 years to developing and evaluating an alcohol education curriculum that was eventually disseminated to every 7th through 10th grade teacher throughout Ontario (Goodstadt et al. 1982). (To protect anonymity, the gender of community representatives have been assigned arbitrarily throughout this paper.)

A community's focus on products can sometimes result in its taking unexpected paths. If left to their own devices, researchers would rarely be content with releasing a program for dissemination—the results of program evaluations are too negative, too neutral, or too ambiguous to justify recommending widespread promulgation. Comparable results of testing new consumer products would result in shelving the prototype, improving the product's effectiveness, reducing its negative effects, or risking a consumer's class-action lawsuit in the future. However, the community appears to accept school-based drug-abuse prevention, regardless of the program's demonstrated impact. This community response to research findings was evident by a school board's dissemination of a curriculum that had been shown to shift some student's attitudes in a proalcohol direction and to increase reported alcohol use. Such discounting of research findings might indicate the community's (especially school administrators') need to appear to be taking action against drug abuse; on the other hand, it might represent an enlightened assessment of the minimal impact, positive or negative, of curriculum-based drug-abuse-prevention strategies.

The divergence between research and community goals finds expression in the researcher's struggle to impose and maintain control over the introduction of new initiatives in the face of the community's demand for universal dissemination. Building on researchers' well-indoctrinated belief in the importance of control groups against which to compare the impact of experimental strategies, researchers favor limited and scientifically controlled (e.g., randomly assigned) exposure to programs. Researchers are, again, most concerned about the validity of their conclusions concerning the impact or effectiveness of the strategy.

As with the introduction of new procedures and drugs for the treatment of catastrophic illnesses, elected representatives are often concerned with the political advantages of the widest dissemination of new initiatives, as well as the negative political consequences of retarding such accessibility. This attitude has stymied the evaluation of many community and government initiatives, including evaluating mass-media programs and pretesting proposed changes in alcohol availability legislation. Because of this reason an experimental evaluation of an Ontario drinking and driving, community-based, mass-media program, conducted more than 10 years ago, still stands as one of the few controlled studies of its kind in the literature (Pierce et al. 1975).

It is probably evident to the reader by this point that the examples presented as evidence of the difficulties encountered by the researcher and the community are a function of local conditions. Such conditions include the single or multiple roles of the researcher and the general attitudes of the community. On the one hand, the researcher may operate solely as the provider of data on the basis of which program and policy decisions will be made by administrators. On the other hand, researchers may be more active in initiating and implementing change in the community. From the perspective of the community, the need for change may be readily identified and embraced, approached with varying degrees of caution, or confronted and opposed. The examples cited here reflect a middle ground, namely, that occupied by a moderate radical acting as both researcher and change agent, and operating in a community environment that is conservative in acknowledging drug problems and the need for improved strategies to prevent drug abuse.

Scientific Rigor Versus Administrative Priorities

Understanding and Accepting Scientific Method

The cornerstone of research is the validity of researchers' conclusions; confidence in their inferences is protected by the scientific rigor of their experimental methodologies and is estimated by the scientific procedures of statistical inference. These issues are rarely understood or appreciated by the community. The community lacks understanding because we, as researchers, do not try to explain the simple and logical basis of experimental research designs (e.g., the need for comparison groups, random selection, random assignment, lack of contamination), and because we fail to report our results in terms that can be understood by those who have not graduated magna cum laude in multivariate statistics. The community also fails to appreciate the value of controlled research because it places more emphasis on product development than on product evaluation, as we have discussed above, and the community shares the researchers' failure to understand how a well-conducted (i.e., scientifically based) evaluation can be integral to good decisionmaking. In addition the process of undertaking and publishing research reinforces the existence of two worlds: the one within which decisions are made by and for the community, and the other within which the researcher exercises principal control over the nature and content of the product, namely, publications.

How many times have I, and others, been guilty of the sin of "scientificism," the promotion of scientific method at the expense of community understanding and appreciation for the value of scientific procedures? Let me count the ways! There is first the use of the tenets of the scientific profession as the basis for criticizing, embarrassing, and potentially destroying the efforts of the nonscientist, as I unconsciously did as a neophyte scientist. A single instance of insensitivity negated the possibility of future collaboration with a large number of other community workers.

There is, also, the oft-repeated experience of trying to satisfy the researcher's need to analyze masses of data that require months' of cleaning and clarification in the face of the community's need for rapid feedback. After all, if political and marketplace decisions can be made every day, without symptoms of obsessive-compulsive behavior, why is it so difficult for researchers to make a timely set of simple, clear, unambiguous statements concerning the implications of their findings? More than one school administrator has publicly stated opinions of my tardy and convoluted handling of research findings that still cannot be printed after a 10-year hiatus—although my research colleagues appear to be more than delighted with my published reports of the project.

Researchers' psychic problems arise, in part, from their need to explore the limits of knowledge, and to do so elaborately and rigorously. This exercise may result in the original inquiry being restated as a research question in ways that no longer meet the community's needs. A simple request to evaluate a newspaper's readership satisfaction was completed after a year's hard work, only to be rejected on the grounds of a poor response rate to the evaluation survey. The response to the next request, to evaluate readers' satisfaction with a magazine, was scientifically flawless and resulted in a fine publication in a refereed journal, but came too late to save the magazine from an untimely death (Goodstadt et al. 1977). The decisionmakers need something short and sweet to assist them unambiguously. Even more traumatic was my experience in presenting the results of a 10-year project to evaluate the operation of a provincewide system of alcohol treatment centers, only to be confronted by the original inquirer with his much simpler initial question, "What is the natural history of the alcoholic?" My conscience was clearer with respect to this offense since I was only the messenger, but I did experience the stress of imminent execution for bearing unasked-for and unwanted news.

Impediments to the Implementation of Scientific Method

Even though sometimes sympathetic to the need for scientific rigor, the community is too often the shoal upon which scientific endeavors are wrecked. Rarely is the community, or its representatives, able or willing to permit the implementation of the basic ingredients essential for scientific rigor.

Random selection of samples. Random selection of participants for research is rarely attempted; most participants are obtained through availability samples, often the result of a community representative's willingness to collaborate in the research. This willingness is open to further scrutiny. In any case the resulting sample is a biased selection from all possible samples by being drawn, for example, from communities that have significantly fewer or more drug problems than average. (Anecdotal evidence suggests that principals and other administrators of schools with above-average drug problems are least likely to cooperate in drug-related research.) Moreover, as already suggested, participation depends on a community's willingness to collaborate. This willingness has often been short-circuited by enlisting community workers who, in turn, have established good relations with their communities. Ultimately, however, this dependence on a community's willingness militates against the sample being drawn randomly from the population of interest. The research results obtained from such a nonrandom sample are restricted in their generalizability to the wider community from which the participating samples are drawn, that is, they have limited external validity. Examples of this flaw in scientific design are legion—the principles of external validity are more often honored in their breach than in their observance.

I have never undertaken a survey or experimental study that depended exclusively on the random selection of participants. In response to a colleague's inquiry about (and implied criticism of) the nonrandom basis of a provincewide student survey, I set about establishing sampling procedures that would be as close to being random as possible, despite my late doctoral advisor's admonition that "it is either random or it is not random." At best, selection of school boards to participate in the Ontario School Drug Survey was random for the initial sample and for alternates to replace boards that refused to participate, but we were able to compensate for refusals by school principals and parents only by statistical procedures. Lack of collaboration by a school board and its alternate, in one instance, created insurmountable interpretation problems for one strata of the survey.

Selection of communities or school boards to participate in experimentally controlled studies has presented me with some of my biggest methodological dilemmas. I attempted in later research to extend my sampling to include a wider representation of the province, thereby increasing the generalizability of the findings. This situation created additional problems, including increased financial cost of such research; increased complexity of the statistical analyses, for example, by trying to accommodate the statistical purist's insistence that the unit of random assignment is the only appropriate unit of statistical analysis; and increased likelihood of ambiguous findings. I have never read of a study that involved more than one community (or school or so forth) that did not find statistically significant differences between communities.

The problem of sample selection is a major challenge to the newer generation of community-based megaprojects, in which only a relatively few communities can be selected for participation. Random selection of less than 10 communities is likely to result in statistically significant community effects without the assumed benefits of equalization of between-community effects. Two preferred solutions appear to exist for this dilemma: the judicious selection of widely different communities to provide a test of the robustness of the experimental findings; and the matching of communities in order to minimize between-community differences before random assignment of communities to experimental conditions.

Random assignment of samples. More attention has traditionally been given to the random assignment of communities to experimental conditions. This attention reflects greater concern for protecting the internal validity of the research, in contrast to concern for external validity, as represented by the previously discussed issue of random selection of samples. Random assignment is so central to scientific methodology and statistical analysis that it takes enormous fortitude or foolishness for me to admit that my research has not always been anything but pure in this regard. In my defense, I suggest that I am not alone in facing the constraints imposed by conducting research in the community—the most obvious impediment being the community representative's unwillingness to abide by strictly random procedures. The common (unacceptable?) cost of participation is some restriction on random assignment. This can occur if school administrators take responsibility for obtaining schools' cooperation. Since administrators know which schools are likely to agree to be an experimental school, this form of school recruitment gives them *de facto* control over the assignment of schools to experimental and control conditions. The same situation has occurred in negotiating with school principals for the random assignment of classes to experimental conditions. Rarely have we not been obliged to accept some restriction on random assignment.

Even where the most determined efforts are made to maintain the integrity of random assignment, reality has a way of imposing its will. In a very carefully designed sample selection of teachers, controlling for school and grade taught, a teacher selected for the no-treatment control was one of the curriculum designers and felt a personal commitment to being included in the experimental condition (thus allowing her to use the curriculum she had worked so hard to create). On another occasion, a teacher used an experimental drug curriculum with a class that had been assigned to the control condition, which destroyed the design for the statistical analysis of a very large and complex study.

Subject loss. Second only to loss of control over randomization is the assault on scientific integrity arising from loss of subjects. The effect of subject loss is similar in that it results in a nonrandom selection of subjects from the parent population and creates a bias in the samples participating in the experimental and control conditions. Empirical evidence suggests that nonrespondents and dropouts are significantly different from those who are retained in the study. Statistical procedures can be employed to correct for dropout rates. Such corrections, however, are usually designed to restore the depleted sample to its original size but are unable to weight the responses of the depleted sample by the unknown responses of the lost subjects.

In reaction to a previously low response rate to a survey, I conducted a detailed examination of differences between respondents as a function of their tardiness in answering. I found highly significant differences among these subsamples, especially in the cohort that was eventually contacted by phone after failing to respond to several mailed reminders (Goodstadt et al. 1977). Similarly the inherent bias of standard general population surveys, when concerned with socially significant issues such as alcohol or drug use, was documented in a Gallup Poll that included oversampling of young males and sampling on Saturday mornings when heavier alcohol or drug users were more likely to be home (Smart and Goodstadt 1977).

The impact of the community on dropout rates should be taken as a given in all research. I have experienced examples that include teachers' confusion of experimental and control conditions (discussed above), the loss of participants in testing sessions as a result of conflicting school activities (e.g., sports), scheduling testing sessions for Friday afternoons when student absenteeism is high, and reducing control of student participation in testing sessions by scheduling sessions en masse in cafeterias and gyms. On several occasions I have been obliged to postpone large projects as a result of labor action by teachers. On one occasion, labor action by janitors caused near riot conditions in a school at which pretesting was scheduled.

The community is not always to blame for nonresponse or dropouts. Winter weather in Ontario has played its role in reducing participation in school surveys, creating insurmountable problems in interpreting regional differences and long-term trends in the Ontario School Drug Survey. Indirectly the community has conspired with human foibles to cause research assistants to miss their preplanned rendezvous, necessitating researchers to make hasty and unwanted adjustments to their testing and program-implementation schedules.

Differences in Constituencies

Communities frequently are accused of possessing a short attention span in their commitment to prevention programs and services. They are characterized as being crisis oriented, with little followthrough once the immediate crisis has passed. School boards and other community agencies appear to be confronted by a bewildering and growing list of ever-more-serious problems. It is not unreasonable, then, that they should respond on the basis of perceived priorities. Nor is it unreasonable that their assessment of priorities should be responsive to perceived pressure from other community forces—agencies, citizens' groups, individual citizens, and politicians. They must also be sensitive to parents, teachers, and even students. However, these real or imagined pressures have important effects on problem definition, research design, and reporting research findings to the community.

Problem Definition

As suggested earlier, the identification of problems and the assignment of resources to address problems are a function of perceived concern within the community. This identification may not reflect the concerns of the majority of the community. Studies rarely are undertaken that would determine community wants or needs. Rather concerns are often the product of the wants of a relatively few individuals, or of a small community group, or even of a single politician or board member. Political importance and public profile are the most important factors in determining the weight given to a community problem, especially in domains such as education where wide discretionary powers are vested in local governments. In this way priorities shift between such social problems as acquired immune deficiency syndrome (AIDS), child abuse, teenage suicide, drugs, alcohol, and alcohol-impaired driving. In the absence of unlimited resources, the community is forced to concentrate its attention on only a few problems at the time, turning to other problems once these problems have been addressed through, for example, the development of a new curriculum or mass-media program.

I have repeatedly experienced communities' shifting priorities and limited attention with respect to drug prevention programs. This inconsistency leads to the following:

- Lack of long-term followup or reinforcement of developed programs.
- Little attempt to ensure adequate dissemination and use of developed programs so that they reach those who will implement the program, that implementors receive adequate training, and that they receive administrative and resource support to ensure continued program use.
- Lack of flexibility in responding to changing community conditions and needs.
- Little interrelationship or continuity between program efforts.

Lack of integration of prevention efforts takes many forms:

- Lack of continuity between prevention programs from the same domain (e.g., drug abuse) targeted at different groups (e.g., different grade levels, or students and parents).
- Compartmentalization between programs dealing with different health issues (e.g., drugs and sexuality).
- Lack of integration between programs emanating from diverse curriculum domains (e.g., health education and English literature).

Failure to integrate reflects the compartmentalization of both problem definition and problem prevention. Rarely are problems perceived as having common roots or solutions.

Researchers are often forced to operate within this context by being responsive to a community's statement of needs or wants, or by tailoring their research interests to community demands. I have, for example, couched my health-promotion-research interests within the framework of preventing AIDS in association with alcohol use. Pressure from the community's definition of needs becomes most acute when the availability of research funds is tied to publicly defined issues.

The community should not be thought to be alone in taking a foreshortened view of prevention. I have frequently found myself tilling the ground in hope of future lucrative (that is, research) payoff. In this case researchers are the ones impatient for results. Their academic reputation depends on a steady flow of research, their paychecks depend on publication rate, their superiors are unsympathetic to researchers who undertake what superiors consider community development—if the work involves the community without immediate publications, it must be community development rather than research.

The same forces have also pressured researchers to seek opportunities to do quick and dirty studies—a pressure to be strongly resisted. Although lip service is paid to the importance of long-term followup of prevention efforts, most researchers are reluctant to commit their research reputation, or energy and other resources, to undertaking multiyear followup studies. The reality of shifting populations within and between communities also militates against the feasibility of conducting such studies.

The community and researcher often possess divergent time perspectives, with the community taking the longer view but without staying power, and the researcher looking for a long-term commitment from the community but requiring a short turnaround time in terms of research publications. These perspectives are a product of differences in their underlying agendas. The community is concerned about problems, their management, and their prevention, however these are defined; the researcher is more likely to be concerned with professional survival than with the loftier task of lessening or preventing social problems. At best, in their defense, researchers are responding to the larger community that currently rewards researchers on the basis of their research and publication output.

Researchers rarely undertake more analysis than is required to meet the requirements of journal editors. My reports and those of other researchers are often short, relative to the time and effort invested in the research, and are usually not written in a form conducive for busy community decisionmakers to use. Response to community needs in this regard would take considerably more time than researchers currently invest in data analysis and report writing, but their findings would have more impact and, in the long run, would lead to better research and better informed administrators. A demand on the researcher to be responsive to decisionmakers' needs, that is, to make "administrative sense" of the data, would likely do the following: increase researchers' efforts to understand the underlying processes at work, rather than merely examining program impact as assessed by relatively few dependent measures; increase examination of results according to sociodemographic and other meaningful breakdowns; and increase attention given to the practical rather than the statistical significance of the findings (for example, by examining the costs and benefits of program impact). My own assumption is that the community and its representatives are as smart as researchers about the underlying issues—they merely see these issues differently, do not use the same language or methods as the researcher, and are interested in using research findings for a different purpose, namely, decisionmaking.

Research Design

Community influence extends to include all aspects of research design and implementation. This influence is especially powerful when juveniles are the object of study. In these instances, the school board, school, and parents have extensive powers to approve or veto participation, or to modify the content and process of the research. Attention has already been given to the influence of the community on some of the key elements of research design, in particular, random selection and assignment. Other examples include the vetting of survey and other assessment instruments, resulting in the exclusion of questions considered to be too sensitive, as defined by anticipated negative reaction from students or parents. As a result I have found it impossible to ask about parental alcohol and/or drug use, even though other research indicates that such information would possess greater explanatory and predictive power than most of the permitted items. To be fair to communities, such questions have usually been vetoed by research supervisors or human subject review committees. Concern regarding the exclusion of sensitive but important questions is reaching new heights as a result of the AIDS epidemic; it is impossible to develop or evaluate AIDS prevention programs without including sensitive material concerning both sexual activity and drug use in programs and evaluation instruments. Experience with AIDS is likely to redefine communities' standards regarding sensitive issues in research.

The impact of the community on research design has also been felt with respect to tracking subjects in followup studies. The community, both its agencies and its individual members, are justifiably concerned that participants' confidentiality be protected. This need is sometimes met by requiring complete anonymity. More often, I have been successful in persuading the community (and ethics committees) that confidentiality will be maintained through the use of unique researcher-generated code numbers. Even this system, however, is not implemented without considerable difficulty, especially in studies involving very large numbers of participants, when there is movement between classes, and when participants do not feel cooperative. In one large study, for example, many months of postprogram time were invested in matching students' ID numbers, on occasion playing the part of Sherlock Holmes in unraveling the confusion caused by human error, by changes in class membership, and by students' sabotaging the code numbers assigned to their postprogram questionnaires.

Reporting Research Findings

The issue of research reports will arise sooner or later in the process of negotiation between the researcher and the community. This issue might include the perennial problem of authorship, since community representatives are not immune to the warm glow of seeing their names in print. More difficult, however, is the issue of the content and format of research reports. The underlying concern in this regard is publicity—good or bad. The community wants to attract good public relations and avoid bad public relations. For these reasons predicting how the community will view publicity of the research findings is difficult.

In my own experience, communities, in the person of school principals, are so anxious to minimize the risk of bad publicity that they will forgo any credit for participating in the research. Moreover, they violate a guiding principle of community research by demanding that no feedback be given to the school, the school board, the press, or other parts of the community, even when complete anonymity is guaranteed. The divergence of views on feedback is well demonstrated in the differing demands imposed by school boards participating in the Ontario School Drug Survey: Some are opposed to feedback about their board's results, and some express no preference, while others go against the researchers' wishes in demanding feedback about their board's results despite the limited validity of drawing conclusions from samples of relatively few schools and grades drawn from individual boards. Researchers, in contrast, usually feel neutral about the public relations issues that preoccupy community representatives; for researchers, knowledge is its own reward, in addition to the rewards that flow from publication of "good" research in "good" journals.

Conclusions

Researchers, as they have been trained in traditional graduate school programs and as reinforced by traditional academically oriented research institutions, possess goals and values that are usually at odds with the communities in which they hope to conduct their research. On the other hand, the community and its representatives are frequently uninformed about the purposes and procedures of the research community. In a sense both researchers and communities are self-serving, that is, they are responsive to their own agendas, needs, and reinforcement contingencies. As suggested by the discussion and examples contained in this paper, this divergence of viewpoints impedes satisfying either set of needs—researchers are obliged to accept undesirable compromises, while the community does not benefit as much as it might from the research to which it has contributed.

Some conditions imposed by conducting research in community settings will never be completely eliminated; these include the vagaries of the weather, the restrictions imposed by limited resources, and, especially, the peculiarities of human behavior in a free society. The latter permits people to choose to participate in research, and be free to collaborate or sabotage, make mistakes, and conduct their professional and private lives as they see fit. The community is not obliged to think as a scientist, to be logical according to the standards of inductive logic espoused by the researcher. The community justifiably responds to other pressures.

Nevertheless, researchers are part of the community and are indirectly supported by it; they have something of significance to offer for the betterment of the community. Therefore, researchers must convey the importance of their contributions to the community, to explain the rationale for their scientific procedures, and to communicate their findings in a manner that meets the community's needs. Reciprocally, if the community is to benefit from researchers' skills and knowledge, it must give them the chance to demonstrate what can be learned from the appropriate use of scientific procedures in addressing community problems.

The two worlds—research and the community—are not expected to ever be in complete sympathy. Real and legitimate differences will remain. However, adjustments by both parties possibly would result in greater mutual satisfaction. Such changes could lead to an enhancement in community-based research and could also accelerate the achievement of healthier and more humane communities.

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Paths Ahead for Server Intervention in Canada

Eric Single

> *Less than 15 minutes after finishing his last beer and leaving the Arlington House Hotel, Clayton Sharpe failed to negotiate a curve in the road. His car plunged over a steep embankment, rolling over repeatedly. Sharpe suffered only minor injuries, but his 16-year-old passenger, Andreas Schmidt, was rendered a quadriplegic.* ***(Solomon et al. 1985, p. 257)***

The Increasing Civil Liability of Alcohol Providers

The noteworthy aspect of this 1983 tragedy was that Schmidt brought a $13 million civil suit not only against the alcohol-impaired driver, Sharpe, but also against the Arlington House Hotel. The case was decided in favor of Schmidt's claim, and the defendants were held jointly and severally liable for 70 percent of Schmidt's losses, or almost $1.4 million.

Schmidt sued the Arlington House Hotel because it provided Sharpe the alcohol that made him intoxicated, and Sharpe's intoxication was in turn a contributory cause of the accident in which Schmidt was injured. Canadian law governing the liability of alcohol providers consists mainly of common law (precedents established from the accumulation of case law). (See Solomon and Uspricht, forthcoming) for a complete discussion of jurisdictional differences in civil liability.) Providers of alcohol are similarly liable in the American states with so-called dram-shop laws; and, given the common law basis of liability, theoretically there is provider liability in all of the jurisdictions within the British Commonwealth that recognize common law. There are important differences between the liability of tavern owners in Canada and liability in other countries. For example, in Canada intoxicated patrons who injure themselves are entitled to recover damages, whereas this is generally not true in the United States. The defense of voluntary assumption of risk is generally very narrowly construed by Canadian courts. Further, in Canada there exists a second and independent basis of liability: in addition to being held liable as alcohol providers, tavern owners may be held liable under common law or statutory provisions of occupier's liability, which are broader than corresponding liability provisions in the United States. Occupier's liability is based on common law in New Brunswick, Newfoundland, Nova Scotia, Saskatchewan, the Northwest Territories, and the Yukon; on the Civil Code in Quebec; and on statutes in the other provinces of Canada.

Until the 1970s, it was uncommon in Canada for individuals to be sued for the conduct of their intoxicated patrons, guests, or colleagues. However, during the past 15 years, several factors have made such suits not only possible, but highly probable. These factors include the expansion of the duties of positive or affirmative action to control the conduct of others in a wide variety of situations; the introduction of mandatory testing of breath and blood samples in the drinking-and-driving laws; the narrowing of the traditional defenses to civil liability; increases in the size of damage awards; and changes in public, government and judicial attitudes.

Furthermore, it is unlikely that government will intercede to arrest this trend. Indeed, the Ontario Advisory Committee on Liquor Regulation (1987) examined the civil liability issue in detail and recommended a strong, new, comprehensive, fault-based, statutory provision of liability. The government has endorsed these recommendations, and action on their implementation is pending. Alternative recommendations that might have diminished the liability of tavern owners and other providers of alcohol were explicitly rejected by the Advisory Committee. Thus, for example, the committee considered, but decided against recommendations to limit the size of damage awards, require mandatory insurance, provide special notice provisions in cases involving alcohol providers, or provide a special exemption in alcohol cases from the principle of "joint and several liability." By virtue of provincial statute (e.g., the Ontario Negligence Act), in negligence suits a defendant is held jointly and severally liable with all of his or her negligent co-defendants. A successful plaintiff, therefore, may collect the entire amount awarded to him or her from any one of the defendants held liable even if the particular defendant was only deemed partially responsible. Thus, for example, in the Schmidt case, the Arlington House Hotel was held to be only 15 percent at fault, yet Schmidt could collect the entire judgment against the hotel. The Arlington House Hotel was entitled to civilly sue the co-defendant Sharpe for his share of the damages awarded to Schmidt.

Although disconcerting to tavern owners and their insurers, the recent development of civil liability for the conduct of the intoxicated represents a new, potentially effective lever for involving licensed establishments in the prevention of alcohol-impaired driving and other alcohol-related problems. The concomitant increase in insurance rates and the threat of insurance becoming less available has increased the pressure on these licensed establishments. Attempts to reduce the toll of deaths and injuries stemming from alcohol-impaired driving have focused almost exclusively on education of the individual driver and the use of criminal sanctions against impaired driving. There are more than 40,000 arrests annually in Ontario for alcohol-impaired driving offenses under the Criminal Code.

Despite these efforts, there remains widespread noncompliance with the law. Reliance on individual education and deterrence through the criminalization of impaired driving have shown only limited success, partly because these approaches neglect drinking environments that give rise to alcohol-impaired driving. Criminal law imposes sanctions against alcohol-impaired drivers, but it does not penalize persons who create the drinking environments and serve the alcohol involved.

Civil law provides an entirely different approach. Although its main function is to provide for victim compensation, the imposition of civil liability on persons who provide alcoholic beverages represents a relatively new and potentially important mechanism for the prevention of impaired driving and other problems associated with intoxication.

The Trend Toward Server Training: A Brief History

The first major server intervention program in North America was instituted in 1979 by James Mosher and Larry Wallack (1979) in California. Many establishments and industry organizations in the United States now have server training programs in place. In Oregon, Utah, and Vermont it is now legally mandatory to train employees in responsible serving practices.

Interest and initiative for server intervention is equally strong in Canada. Indeed, the civil liabilities of licensees as providers of alcohol and as occupiers is generally more extensive and broad based in Canada than in the United States. In 1983 a course on responsible beverage service was developed by the author for implementation in the hospitality curricula at two local community colleges in Toronto. From 1984 to 1986, a number of server training programs emerged in Canada, mainly sponsored by the hospitality industry, including those of private establishments and hospitality organizations.

After 2 years of development, in 1986 the Addiction Research Foundation (ARF) of Ontario introduced an extensive server intervention program (Simpson et al. 1986). The ARF program, which was formally endorsed by the Liquor Licence Board of Ontario (LLBO), consists of a half-day workshop for servers and a longer training session for owners and managers. The program covers the following topics: (1) alcohol and the law, including a videotaped presentation on civil liabilities; (2) the health perspective, including the effects of alcohol and factors that influence impairment; (3) preventing intoxication, including how to recognize intoxication and diplomatically cease service of alcohol; and (4) managing the intoxicated patron, including a discussion of safe transportation strategies. The course for owners and managers is lengthier because it involves a more detailed examination of many issues and the development of a specific set of house policies aimed at preventing problems in each participant's establishment.

The ARF program has undergone major changes since its inception in 1986. In 1987 a major hospitality industry organization, the Ontario Hotel and Motel Association, decided to use the ARF program instead of its own. Insurance companies were also enlisted in support of the program, providing discounts to clients who train their staff in the ARF program or formally requiring the training to qualify for liability insurance. In 1988, the ARF program was revised and reorganized. Program materials were updated and long-term public health goals moderated to make the program more realistic and acceptable to bartenders, waiters, and waitresses. It was decided that the Foundation would provide the program on a franchise arrangement to the community colleges, hospitality organizations, and private educational specialists who would deliver the program. Thus, ARF provides the program manuals and materials, trains the delivery service organizations, tests and certifies program participants, and conducts periodic inspections of delivery organizations. The actual training is carried out by others. To date, over 3,300 persons have received training in responsible beverage service under Server Intervention Program ("SIP"), the name of the ARF program.

Government Policy Regarding Server Training

The provincial agency responsible for regulating drinking in on-premise outlets, the LLBO, has a strong interest in server training. In addition to endorsing the ARF program, the LLBO developed a half-day workshop, required for new licensees and transfers, which uses ARF program videotape and materials. This workshop is given to owners and managers of more than 3,000 establishments (approximately one-fourth of the total number of licensees) each year. The topics covered in this workshop include not only the topics covered by the ARF program but also information concerning regulations and procedures of the LLBO. The LLBO program is aimed at increasing compliance with the rules and regulations governing the service of alcohol. Server training is thus seen as a complement, not an alternative, to enforcement.

In 1987 the government conducted a review of alcohol regulations in the province of Ontario. In addition to the recommendation for a comprehensive statutory provision of liability, the committee recommended that server training be mandatory as a condition for employment in the hospitality industry (Ontario Advisory Committee on Liquor Regulation 1987). A similar commission in British Columbia has also recommended mandatory server training.

The recommendations of the Ontario Advisory Committee are currently being considered by the Ontario Cabinet. Consideration is being given to using the ARF program as the model program to be delivered to all 150,000 persons in the hospitality industry. As a preliminary step toward mandatory training, the LLBO now routinely requires that the serving staff of licensed establishments that appear before the Board for transgressing the rules and regulations of the Liquor Licence Act must be trained by the SIP program.

At the Federal level, the National Steering Committee on Impaired Driving has given financial support for a national conference aimed at the development of a network of server training specialists. The focus of this conference was on policy issues and implementation planning for extending server intervention programs.

Server Training: Does It Work?

Preliminary evidence from the United States and Canada indicates that server training programs are effective in reducing intoxication. Three evaluation studies of these programs were conducted in the United States and one in Ontario.

The first evaluation of a server training program was conducted by Dr. Robert Saltz of the Prevention Research Center in Berkeley, California, with regard to a comprehensive alcohol problem prevention program at a U.S. Navy service bar in San Diego. Saltz's (1985, 1986, 1987) analysis indicated a considerable reduction in the portion of patrons served to intoxication as a result of the program. It is noteworthy that this decrease was achieved without a reduction in overall alcohol consumption by patrons. Thus, the program succeeded without affecting revenues. However, both the comprehensiveness of the program (18 hours of training plus other supporting management policies) and the closed nature of a military base preclude generalizing these findings to ordinary bars and taverns.

A more typical server training program, Training for Intervention Procedures by Servers (TIPS) was evaluated in two bars in a rural university town (Geller et al. 1987; Russ and Geller 1987). Using actors posing as patrons, the researchers determined that trained servers were less likely to serve patrons to the point of intoxication or beyond, and that the amount of gratuities did not suffer as a result.

The third evaluation was conducted by the Program Evaluation Division of the U.S. National Highway Traffic Safety Administration. The focus of the evaluation was the Techniques of Effective Alcohol Management (TEAM) program in seven National Basketball Association arenas. The program was effective in facilitating the development of policies aimed at preventing intoxication and alcohol problems in the arenas. Data on sales (collected from two arenas only) indicated lower overall levels of beer consumption, but higher sales of food and nonalcoholic beverages. Attendance also increased.

The only Canadian evaluation was conducted by researchers from the ARF in Thunder Bay, Ontario (Gliksman et al. 1988). The study used a pretest and posttest design, with observations collected in eight taverns before and after serving staff in four of the taverns were given the ARF server training course. Professional actors posing as patrons enacted six scenarios involving behaviors covered in the training course, such as ordering doubles, frequent ordering of drinks, drinking to intoxication, and arriving intoxicated.

The study found significant positive changes in knowledge and attitudes by the trained serving staff. Most important, the observation of their reactions to the actors' behavior revealed significant changes in dealing with patrons who were intoxicated, seeking an excessive number of drinks, troublesome, or apparently underage. After taking the course, servers were much more likely to intercede to prevent intoxication and to properly manage underage or intoxicated patrons.

The results of the Thunder Bay evaluation are very encouraging. It should be noted, however, that two factors may have contributed to the strength of the findings. First, the relatively high level of alcohol-related problems in Thunder Bay bars and taverns made it likely that any intervention would have some positive effects. Second, the evaluation concerned only short-term effects (i.e., within 1 month). Further studies are required to assess the benefits of server training programs over a longer period of time.

The Future of Server Training: Prospects and Problems

Preliminary evidence indicates that server training programs succeed in reducing intoxication in licensed establishments. Although further research is required to assess long-term impacts and the importance of variations in program content and format, one may conclude that the following factors are important to the success of server intervention programs:

1. **Management support:** The training of servers must be supported by a management policy that does not undermine the goals of the program. It is self-defeating to combine the training of staff in responsible serving practices with promotional strategies that encourage heavy alcohol use. Management must support servers when they carry out the program, and training must be directed at both servers and managers.

2. **Accurate and clear documentation:** Training requires clear, concise written materials with a sound scientific and legal basis. Manuals and audiovisual materials should be complete, involving historical, legal, and public health perspectives. Goals should be clearly defined, and the economic interests of the licensees must be considered. A key distinction of the most effective programs is an emphasis on the prevention of problems rather than simply intervention once a problem occurs.

3. **Enlistment and compliance:** Even high-quality programs may have limited impact if they are perceived as a nuisance or of little value to licensees. It is ironic that the first licensees to train their staff in responsible serving practices were probably the establishments with relatively few problems. To enlist more establishments, it is important that the hospitality industry itself be part of the program development and delivery. To ensure compliance, programs should incorporate followup and evaluation procedures.

It is not yet clear if it is necessary or even desirable that training be mandatory rather than voluntary. In either case, the success of server training is likely to depend on its impact on the economic well-being of the establishment. In this respect, one might postulate that there are three types of licensed establishments. First are the licensed establishments that rarely serve patrons to intoxication and have low rates of alcohol problems. These include restaurants, and most of the more expensive nightspots, downtown lounges, and hotel bars. Because rates of problems are already low, server training will not have a major impact.

Second are the establishments, such as skid-row taverns, that depend mainly on high-volume drinkers for most of their business. These establishments would suffer the most economically if they applied the server training programs and stopped serving alcohol to intoxicated patrons. It would be unrealistic to expect a major impact in such places.

Finally, there are the majority of bars and taverns, which do occasionally serve patrons to intoxication, but do not depend on heavy drinkers for the bulk of their business. Many, if not most, downtown bars, neighborhood taverns, and campus pubs are in this category. Not serving patrons past intoxication will marginally reduce alcohol sales in these establishments, but the preliminary evidence indicates that this loss can be offset by increased sales of food and dealcoholized or low-alcohol beverages, by lower insurance premiums, and by the lower risk of civil liability.

The initial success of server training programs confirms the expectation that prevention programs can be effective in reducing alcohol problems if two essential conditions are met. First, prevention programs are more likely to succeed if they are broad based, with support from many groups in the community. Server training clearly enjoys widespread support from regulatory agencies, public health interests, citizen groups, insurance companies, and even the alcohol industry. Second, prevention programs are more likely to succeed if they involve a comprehensive approach rather than relying exclusively on either legal sanctions or education. Server training is such an approach, involving a combination of the threat of civil liability with the training of servers and managers in licensed establishments.

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Environmental Design to Prevent Problems of Alcohol Availability: Concepts and Prospects

Friedner D. Wittman

This paper explores prevention planning through an environmental design approach that encourages self-directed uses of the community's own resources to prevent community-level problems of alcohol availability. Specifically, we are interested in community experiences in modifying sociophysical settings to achieve planned reductions in alcohol problems. Drawing from experiences with environmental design in several communities in California, the paper attempts to stimulate interest in further development of such environmental design approaches.

Rationale for Environmental Design

Relationship Between Alcohol Problems and Alcohol Availability

Studies over the past 20 years have increasingly demonstrated an association between community settings for alcohol availability and alcohol problems, by which we mean the times, places, and occasions in the community where alcohol is present for sale or consumption. These community settings include retail outlets; public places where alcohol is available or routinely consumed; and settings and circumstances throughout the community where alcohol use is routine. On balance, the research suggests that reducing community-level availability might lead to reductions in alcohol problems (MacDonald and Whitehead 1983; Room 1980, 1984). The following discussion directs attention to such reductions through locally determined prevention policy.

Observations on Community-level Responses to Problems of Alcohol Availability

Generally, it has been found that communities have a greater capacity to control alcohol availability than may have been previously realized. Using the community's regulatory powers to modify the settings for alcohol availability has been the subject of several studies in California communities. California's alcohol beverage control laws formally reserve virtually all licensing powers to the state although many States and Provinces in North America allow local jurisdictions to have a greater role in the control system than is permitted for California communities. The lack of such powers has forced California municipalities to be creative in their use of planning and zoning powers—powers that are generally available to communities in North America.

Studies have found that counties and municipalities have substantial powers to shape the community's alcohol environments for preventive purposes (Wittman 1980, 1983, 1986; Wittman and Hilton 1987; Wittman and Shane 1988). These powers include regulatory authority over retail alcohol outlets through local planning and zoning permits; controls over alcohol sales and uses in public places (streets, parks, stadiums); and the capacity, through education and persuasion, to influence customary drinking practices and drinking patterns among local organizations and community groups.

California cities (and probably communities in the rest of the United States) presently use only a small portion of their powers for prevention purposes. Further, neither community groups or local agencies generally understand nor use the options available at the local level for alcohol control (Wittman 1980, 1986; Wittman and Hilton 1987). However, those community groups and agencies that have experience with using their powers to alter the environment for alcohol availability experience satisfying successes with them.[1] Successes in one community have been adopted by other communities; "copy-cat" ordinances are leading to widespread adoption of successful prevention strategies among many other communities.[2]

Room (1984) and Smart (1982) argue that small-scale, fragmented, and isolated availability control policies do not appear to be effective in reducing or preventing alcohol problems. Larger-scale and more comprehensive initiatives supplemented by supporting programs and policies, and particularly those endorsed by those groups to which they are applied, appear to be successful in reducing problematic consumption (cf. Smart 1974). However, while fragmented and isolated control activities can be displaced or subverted within the community, small-scale interventions can also be systemic and comprehensive within clearly defined environments. Small-scale interventions should not be assumed to be fragmented control responses. Examples exist of the successful use of several resources and a comprehensive intervention strategy applied to highly specific, highly localized problems (Wittman 1982b). Such interventions have been successful within a given community (e.g. Oceanside, Calif.[3]).

Smart's (1974) review of the acceptance of wartime restrictions on alcohol availability suggests the importance of official and popular support for local control measures. Smart's and similar research studies usually observe how control measures imposed by the state are received at the local level. In contrast, when establishing availability-control measures from the bottom up, the potential displeasure of the alcoholic beverage industry and the State's elected officials need to be considered.

Absence of Federal support has affected development of community-level planning for the prevention of alcohol problems. An 8-year hiatus in NIAAA-funded demonstration grants has only partly been made up by State-level support. Without formal demonstration and research projects, community planning for availability has not been able to proceed beyond its haphazardly developed current state.

State-level support has been forthcoming in California for demonstration and planning projects to stimulate community-level initiatives. However, California and other States generally do not fund long-term, controversial, or basic research. Original expressions of State-level interest in community planning are therefore difficult to follow through into well-worked-out planning policies (California and New York State plans[4]).

State- and Federal-level controls have a key role to play in alcohol availability (e.g., economic controls through tax increases; see Moskowitz 1989); however, local support is necessary for State-level policies that might otherwise be subverted by moonshining, bootlegging, and beverage substitutions (Wittman 1982a). Additionally, State regulations depend heavily upon collateral local legislation to manage the distribution of availability in each community (Rabow et al. 1981). These observations suggest the value of partnerships between State and local initiatives, rather than conflicts over preemption between the levels of government.

Finally, local jurisdictions in California bear increasing responsibility for control over alcohol availability (Mosher and Colman 1989). Overloaded local agencies are not looking for more work, and community groups are not eager to take on their problems without backup support. However, community agencies and groups in California have shown strong interest in improving their own capacities to address problems of alcohol availability (League of California Cities[5]), and the California Department of Alcohol and Drug Programs has responded with a State-wide program of planning consultation and technical assistance (California Dissemination Program[6]).

These diverse observations suggest that local powers are an untapped prevention resource, in keeping with Room's (1980) observations about potential uses of community-level resources for prevention initiatives. The time has come to develop workable models for local planning that can support community-level initiatives to prevent availability-related problems (Wittman and Burhenne 1985).

Community Design for Prevention-Sensitive Alcohol Environments

How can communities' own extensive powers be used effectively for prevention? What could be expected if local communities did use their powers more completely? The breadth and scope of local powers and the pervasiveness of alcohol availability suggests that substantial reductions in alcohol-related problems might be possible. Communities could adopt a public health orientation toward alcohol availability that would encourage each community to adopt measures to eliminate the particular patterns of high-risk drinking that impose the most unbearable costs upon the community's residents (Beauchamp 1976; Room 1980).

Community Prevention Agendas

Generally, communities' programs on availability can be expected to develop according to progress in three areas: (1) the extent to which community groups and agencies view alcohol availability as problematic; (2) the extent to which local agencies and groups create local capacity to utilize their own local planning resources for prevention purposes; and (3) the extent to which emergent policy can overcome resistance to making changes in the alcohol environment.

Three patterns of community action on alcohol availability are possible. At the most modest level, few if any changes occur in a community's alcohol environments. Inertia and resistance to change continue to overwhelm whatever shifts may occur in problem perceptions or in changemaking capacity.

At a middle level, a community copies shifts in alcohol policy that occur elsewhere, either based on national and State campaigns or on successful examples from neighboring communities.

At the highest level, communities develop their own policies based on their own analyses and preferences for redesigning the community's alcohol environments. This level will be the most interesting for research purposes and for exploration of programmatic innovations in the design of settings, policies, and drinking practices.

Strategies to Alter the Alcohol Environment

The suggestions which follow are based upon observations of communities that have become active in local prevention planning for alcohol availability.

Use a workable model for introducing profound change into community settings. Municipalities contemplating preventive modifications to the community's alcohol environments will have to modify deeply seated patterns of meanings and uses of the locality's alcohol settings. These patterns are likely to be woven into the community's history (Benham 1982) and will be complicated by the involvement of entrepreneurial organizations (Morgan 1980). The community will be faced with shifting its beliefs and practices regarding alcohol outlets from a laissez-faire market orientation requiring little policy participation to a prevention-oriented perspective requiring a great deal of intervention.

Choices will have to be made about the pace and extent to which such shifts occur. A modest public health perspective would adopt a gradualist, deliberate, well-grounded, problem-specific orientation toward change. The more extensive the appreciation of problems, and the greater the willingness to act, the broader and more sweeping this public health orientation might become. A more radical community-reform perspective would adopt a confrontational, politically active orientation. A radical perspective is more likely to be accepted if it is founded in support from many community organizations and has an empirical base.

Focus planning upon eliminating or reducing high-risk settings. Goals for changing the community alcohol environment that emphasize risk-reduction and problem-reduction generally benefit nearly everyone; they are defensible in terms of mandates and powers of public agencies to protect the citizenry's health, safety, welfare, and morals, and are acceptable to most local groups and agencies. Thus risk-reduction goals provide broadly acceptable and defensible goals for the development of specific objectives. The Prevention Policy Bill of Rights provides an excellent general statement of such goals that serve for the development of specific objectives.[7]

In contrast, goals aimed at "appropriate" or "acceptable" drinking levels may be problematic. Such goals, often proposed by the beverage industry, are vague and difficult to operationalize, may encourage high-risk drinking, and may encourage conflict between different community groups' drinking styles and cultures.[8]

Encourage participation by local groups and agencies in deliberations on the meanings and uses of alcohol settings. Typically, those who live in the community are excluded from participating in decisionmaking that affects them. Wherever possible, strive for opportunities for wide participation in the planning process.

Problem assessment within the community will help open the planning process to increasing identification of community problems with alcohol availability. If the problem-assessment activity leads directly to organizing action on specific alcohol problems, opportunities for recruiting participation will expand considerably (Shane and Cherry 1987).

Expert consultants. Consultants can be helpful on an increasing number of technical issues concerning specific interventions and planning processes. Several activities are currently under way in California to develop consultant pools and information resources for community planning. Community-level planning can anticipate increased availability of specialty consultants over the next few years.[6]

Alcoholic beverage industry. The industry's primary interest in alcohol sales creates a prima facie conflict of interest with community-level problem-oriented prevention planning. Planning participation by nonresident members of the beverage industry should thus be restricted to simple statements of the industry's position on the issues. This restriction excludes the industry's active participation in local decisionmaking or funding for community-level prevention activities.

Utilize research information about uses of settings and associated problems; include research findings in policymaking and in the design of alcohol settings. Risk-reduction strategies that use local planning and zoning ordinances must be grounded in experience to demonstrate and justify public benefits that may reduce private economic advantage (Village of Euclid vs. Ambler Realty Company 1926). Without reasonably well-researched findings, legislation will be open to challenge through the courts. Restrictions should be able to demonstrate the relationship between the legislation and actual reduction or elimination of problems. Local groups are extremely attentive to results of legislation they have worked hard to obtain.

Reliable problem-assessment instruments are sorely needed to identify problem experiences associated with community-level availability (Shane and Cherry 1987; COMPRI Project[9]). One benefit of the problem-identification activity is its capacity to alert local people to the prevention planning enterprise and to attract their participation. Previous experiences with problem identification suggest that many local people are eager to participate in planning to prevent alcohol problems, but have lacked the opportunities to do so (Wittman 1989; Wallack 1984-85).

Develop sound planning information that supports community-level planning. Local perceptions about the meanings of, uses of, and problems with the alcohol environment are critical to initiation of participatory planning activities. Local participants are generally eager to work on problems they think are important; people are less likely to participate in support of priorities that are not their own.

Three kinds of information about alcohol problems appear critical to preventive planning for availability controls: official documentation of alcohol problems; operational information about alcohol-problem experiences among the community's agencies and organizations; and experiential information about community groups' direct experiences of problematic availability (Wittman and Shane 1988).

Official information. Official information is the formal record maintained on alcohol use and related problems by data-collecting organizations. Nominally, this information is vital for planning. Practically speaking, the information often has no immediate value for local-level planning. The records are likely to be incomplete, inaccessible, restricted, and too highly aggregated for analysis of alcohol problems at the local level (Shane and Cherry 1987). Additionally, official information is often not attractive or compelling to local planners, decisionmakers, and community groups, unless it can be tied directly into local experiences of alcohol problems (Wittman 1986).

Operational information. One approach to making official information attractive for local planning purposes is to supplement it with operational information identifying alcohol-problem experiences from the perspective of the agency and the organization. For example, tallies by a local judge may document alcohol involvement in cases that otherwise might not be recorded (e.g., Willits, Calif.[10]). A special survey of high school students might be taken to pursue questions on local concerns and to compare local student experiences with State or national averages (Shane and Cherry 1987). These analyses provide a firmer factual basis for prevention planning; they also help engage local agencies and organizations in the planning process.

Many technical aspects need to be decided in order to collect operational information: sampling of agencies and organizations; selection of respondents within agencies or organizations; interview format; analysis protocols; reporting formats; utilization for planning purposes; limitations on acceptability; and expansion or integration of operational information into formal record-keeping systems.

Experiential information. Experiential information identifies the attitudes and concerns of community groups toward alcohol-availability issues. This information provides an understanding of problem priorities and issues that are of the greatest apparent concern to the community. Further analysis and probing can test the sources and strength of these concerns, and can identify possibilities for their mutability into more prevention-significant orientations (Douglas 1986). Experiential information thus provides planners a vehicle to shape the community's understanding of issues and to stimulate local responses.

Use a clearly defined planning process when designing the community's policies and settings for alcohol availability. The most stable aspect of an environmental design approach to the prevention of availability-related problems is the planning process itself. Specific problem environments will vary from community to community: Different groups and agencies will choose to participate; public sentiment will vary; agency support will vary from community to community and may be politically volatile within a given community; and knowledge about the efficacy of intervention strategies may be meager. In the presence of such instability of content and circumstance, a stable planning process is vital to sustain local agencies' efforts.

Local planning and zoning activities provide a model for a planning process that serves well the interests of participant-based public health planning, both for the individual case (i.e., review of an individual alcohol outlet permit application), and at the broader community level (i.e., distribution and operation of outlets in the community). The planning process can be slow, expensive, frustrating, and sometimes alienating for its participants. Nevertheless, the process also has the capacity to encourage debate and deliberation on all sides of availability issues; to favor decisionmaking in the interests of public health and safety considerations; and to protect interests of community groups and agencies against economic exploitation.

Central to the exercise of local controls on alcohol availability in California is the Conditional Use Permit (CUP) (Wittman 1983, 1986; Wittman and Shane 1988). The CUP permits a community to regulate times, locations, and conditions of operation for alcohol outlets both generally, and on a case-by-case basis. CUPs are discretionary—communities can choose to require them by enacting laws that apply them to alcohol outlets. Communities that do not adopt CUP's (i.e., that require only a regular zoning permit) leave the distribution of outlets largely to the discretion of the entrepreneur and will experience great difficulty in taking action against problematic outlets.

Conditional-use planning and zoning includes four basic sub-processes: a fact-finding process requesting information from all parties that may have bearing on the proposal at hand; a hearing process to debate the meanings, uses, and consequences of the proposal; a decisionmaking process on whether to permit or deny the proposal; and an appeals process through the local legislature to test whether the proposal has been fairly and correctly reviewed. Although not every permit application requires extensive review, the CUP guarantees that such review can be provided for potentially troublesome outlets and that sanctions can be taken against operating outlets that become troublesome.

The process works. Agencies new to the zoning game for alcohol start out afraid of the workload, but planning and police departments generally find the process far preferable to the after-the-fact problems with which they would otherwise have to deal. Outlets that are likely to become problematic become discouraged from even beginning the CUP process, and don't bother to apply. Those outlets that enter the process learn how they are expected to conform; those that don't lose their permits. Cities that have shifted to CUP processes thus report successful experiences both in reducing problems and in bearing up under the administrative workload.[1,3]

Create an infrastructure for continuing maintenance and implementation. Preventive design for alcohol availability can never be complete since new outlets, new proposals, and new land uses in the community will always occur. Additionally, drinkers and the beverage industry will always exert pressure to erode the preventive capacity of the community's design for availability and its administration.

An illustration of a continuing planning infrastructure has been suggested by Wittman and Shane (1988, pp. 102-115). The infrastructure consists of two basic elements:

- A central planning body or commission provides a focal point for community concerns about alcohol availability planning. Supporting the central planning body are select standing committees for media/public information; for recruitment of members and volunteers to work on alcohol issues; and for fund-raising/outreach/advisory functions.
- Specific task groups are created to deal with specific availability-related problems as they arise (e.g., a task force to deal with problem bars in the downtown area; a task force to deal with teenage parties in rented hotel rooms). The central planning apparatus exists only to support these task forces in modifying the community's problematic alcohol environments. If there are no operating task forces, there is no need for a central planning body.

Future Prospects

The challenges to implementation are formidable, but the forces supporting local planning have rarely been stronger.

Understanding Planning Implementation

Within the broad theory of participatory planning, myriad questions about implementation require answers for which theory offers only clues as planning decisions are made. The details of action within each community will determine whether the prevention-oriented planning for availability will be successful (Pressman and Wildavsky 1979).

Some problem areas that will require continuing attention include the following:

Scale and scope of planning activities. At what levels of aggregation should coordination be sought among agencies and organizations for prevention? Planners faced with establishing a realistic scope for availability-planning initiatives probably should choose specific problems and subcommunity levels of organization and aggregate them, rather than proceed from the top-down (Wittman 1989).

Problems of evaluation. The more complex the interactions and the larger the number of variables, the more difficult it will be to make headway on evaluation of prevention initiatives. Relationships between programmers and evaluators will be strained—evaluation follows planning's lead—but planning must make concessions to the evaluators. Community planning and design is a curious mixture of art and science; highly productive planning is often extremely difficult to analyze, and its practice involves special skills that are difficult to teach. Many variables are juggled simultaneously, and decisionmakers interact with one another in ways extremely difficult to capture (Schon 1983).

Initiation of planning activity. Generating interest at the community level involves organizing and invention. At what point does stimulation become an overly aggressive, counterproductive intrusion into the community's affairs? This question touches especially on roles of external experts and organizers. Superior knowledge can distort a local process to the point of incapacitating or alienating local action. Yet assisting local groups to discover the same lessons over and over is often frustrating, expensive, and may enable alcohol-related problems to continue as nothing changes.

This question also touches on uses of special events such as tragic auto crashes that sometimes offer extraordinary opportunities to mobilize local action. To what extent does initial reaction (often one of great pain and loss) offer an organizing point for local planning?

Availability of necessary planning information. In the United States, local information about uses of alcohol environments, alcohol sales, and alcohol involvement in community problems is generally unavailable. Design and collection of this information will continue to be an expensive and elusive part of the planning process. Strong resistance may be expected from the alcoholic beverage industry and retailers to providing voluntary information about alcohol sales and alcohol problems. State agencies may resist furnishing information or inhibit localities from collecting it themselves.

Obstacles to information availability are not likely to be overcome without the combined efforts of alcohol researchers and prevention planners to generate appropriate data for research and planning activities. The alcohol field to this point has not demanded better research data and better planning information systems, although note has been made of their significance (Holder and Blose 1987; Wittman 1986). Efforts are just now getting under way to generate local planning information specifically designed to meet the needs of prevention planners (e.g., COMPRI Project[9]).

Alcoholic beverage industry reactions against community-level planning. The industry will probably do a great deal more to fight local environmental planning for prevention than simply to resist requests for information. Recent California experiences suggest that other strategies of opposition may include the following:

- Lobbying the State legislature or State agencies to eliminate the state's public support for local planning and/or to eliminate local powers to act.
- Designing public information campaigns to discredit various aspects of the local planning activity, or to offer alternative images and programs designed to distract and confuse the public's support for local planning.

- Co-opting local planning processes through offers of funding and sponsorship.
- Filing or threatening to file lawsuits against communities that restrict alcohol sales.
- Purchasing scientific studies that produces findings to support industry's position.[2]

Availability of knowledge about effective preventive policies and design for drinking settings. It would be extremely helpful to have technical knowledge available about the effectiveness of management prevention policies and designs for particular alcohol-use settings. Implementation of local planning currently must include original research on what works in the preventive design of alcohol-use settings such as bars, parks, and parties. Intervention ideas should be gathered from the alcohol field as it develops, both from researchers (cf. Graham 1985; Schaefer 1985; Single and Storm 1985), and from the experiences of local communities (cf. Wittman and Shane 1988).

Prospects for Community-Level Prevention Planning

Community-level prevention planning for alcohol availability is likely to have a strong future.

Preventive planning for alcohol availability encourages robust local problem-solving activity. Communities that confront availability-related problems often develop their own creative solutions with benefits that extend to the community beyond immediate difficulties. For example, mushrooming of alcohol outlets in one commercial-residential neighborhood in San Francisco led to a general threshold ordinance that has created orderly patterns for commercial development in 13 such neighborhoods. Thus community planning may become more robust generally as local agencies and community groups become familiar with prevention-oriented planning for alcohol availability.

Participatory approaches to community planning for availability meet individuals' deep needs for mastering their environment. The extraordinarily positive responses to invitations and recruitment to participate in local prevention planning suggests that planning for alcohol availability appeals to people's deep needs to manipulate the environments in which they live and should be studied further. Environmental design research suggests theories to explain these needs, e.g., to control one's proximal environment and to exercise powers to create the settings in which one lives (e.g., Alexander et al. 1977). However, environmental design research has done little work in the alcohol field per se. Though a few investigations have been conducted (e.g., Graham 1985), environmental design research is a fertile area for future development.

Rapid dissemination and quick diffusion of planning ideas. Communities' capability for rapidly sharing among each other workable solutions to planning and zoning problems helps spread ideas and provides a network for the diffusion of innovative ideas. The rapid spread of county and municipal ordinances banning the sale of alcoholic beverages in gasoline stations, coupled with the beverage industry's swift negative response, exemplifies the significance of networking and sharing information among cities to establish prevention initiatives.[2]

State and federal support for local planning initiatives. Finally, local planning is in many respects a creature of State and Federal policy. Federal and State agencies continue to place major responsibilities on local communities to take leading roles in generating prevention initiatives. Thus one would expect Federal and State support for local community initiatives and would hope for some official enthusiasm so that, with training investments, local availability planning can be done without making major demands on Federal or State resources. Investment support from Federal and State levels would be particularly welcome both for research and evaluation studies and for program development through demonstration grants and by stimulation of networking and technical assistance services.

Notes

1. South Central Organizing Council (SCOC) in Los Angeles, California, a consortium of churches and labor unions, experimented unsuccessfully with public appeals to law enforcement officials to eliminate a variety of problems associated with liquor stores in South Central Los Angeles. SCOC then worked with city planning and city attorney offices to gain trial modifications of Los Angeles City ordinances to increase participation by South Central area community groups in planning and zoning for alcohol outlets (Boyer 1983). The year after the change took effect, 21 or 25 liquor store permits were turned down, and license revocation procedures were begun against three existing outlets. The SCOC's special committee for zoning reported substantial (though undocumented) decreases in problems that had been of concern, and expressed satisfaction with results of its efforts. After a 3-year trial period, the City Council of Los Angeles converted the provisional ordinances changes into a permanent ordinance for the entire city (Wittman and Shane 1988, pp. 119-127).

2. Alcohol/gasoline sales controls. In 1985, about 11 percent of California communities regulated alcohol sales in gasoline stations. By 1987, an estimated 30 percent of California communities had such regulations, as a ground swell of interest swept through the State following efforts by alcohol policy advocates to inform and to organize both local communities and the state legislature to ban concurrent sales of alcoholic beverages. The groundswell stimulated a counter-lobbying movement by alcohol retailers, Food and Fuel Retailers for Economic Equality (FFREE), to obtain state legislation forbidding localities to

ban alcohol sales in gasoline stations. FFREE's campaign involved a 2-year orchestration of threatened lawsuits, specially commissioned research to challenge the public health utility of local ordinances, and intensive lobbying of State legislators, statewide agencies representing cities and counties, and alcohol programs.

3. Oceanside, California, created a multi-component program to clean up the town's downtown/beach community following years of economic neglect and problems associated with high concentrations of alcohol outlets. The program of restricted zoning of alcohol outlets, urban redevelopment buyouts of problem establishments, specially targeted preventive law enforcement, and new ordinances regarding drinking in public and drinking on the beach has been given major credit in the revitalization of the community (Wittman and Shane 1988, pp. 131-135).

4. State alcohol agencies in New York and California in the mid-1980's produced state plans with major commitments to prevention of alcohol problems through public policy approaches. These plans are notable for their vigorous recommendations on a variety of community-level regulatory and planning activities. See Five-Year Comprehensive Plan for Alcoholism Services in New York State, 1984-1989: Focus on Prevention (1986 Update). Albany, N.Y.: New York State Division of Alcoholism and Alcohol Abuse, 1986. See also Framework for Community Initiatives, California State Department of Alcohol and Drug Programs. Sacramento, California, February, 1985.

5. The League of California Cities responded quickly to interest among the State's 441 cities regarding regulation of alcohol sales in gasoline stations. The League hosted three statewide seminars and published an article on local alcohol control in its journal all within 1 year. This exposure, which reached virtually all cities, probably did much to aid the rapid 1985-87 expansion of local regulation of alcohol sales in gasoline stations.

6. To stimulate communication between cities and statewide organizations on preventive regulation of alcohol availability, the California Department of Alcohol and Drug Programs (DADP) supports the University of California to provide technical assistance, training, consultation, and education in the use of a community planning manual (Wittman and Shane 1988). The "Community Planning Project" is expected to stimulate community groups and local agencies to make increased use of local ordinances, to adopt new service policies, and to modify settings where alcoholic beverages are consumed, to prevent locally identified alcohol problems. DADP also is contracting for technical assistance in alcohol service program development, and for provision of information resources to promote community-level planning.

7. The Alcohol Policy Bill of Rights is a multi-point program developed to stimulate local debates on options for public policy at the community level. The

Bill of Rights is available from the Trauma Center, San Francisco General Hospital, San Francisco, California. Authorship: Council on Alcohol Policy, Burlington Vt.: National Association for Public Health Policy, 1987.

8. Alcohol advertising in the community. Alcohol distributors and producers provide beverages and promotional materials whose appearance may predominate at public events or celebrations, particularly where college-age people are involved. Billboards are also major vehicles for alcohol advertising, particularly in minority communities. Jean Kilbourne, 51 Church Street, Boston Massachusetts 02116, provides a wide range of materials on problem- and prevention-significance of alcohol advertising.

9. COMPRI Project. The COmmunity PRevention Initiative project (Horizon Services, Inc., Hayward, California) is a "new generation" example of a comprehensive, relatively long-term, evaluated community-level prevention project planned by a county alcohol program rather than by the State (funding is anticipated for 3.3 years at $250,000 per year). Alameda County Department of Alcohol Programs hopes to establish a model program. One of COMPRI's first findings has been that information on relationships between alcohol availability and local alcohol problems is extremely spotty, and must be generated locally as a first step in systematic planning activity.

10. Willits, California, prevention planners found that routine categories of agency reporting systems buried a good deal of information about connections between the presence of alcohol and the occurrence of various community problems, in those circumstances in which alcohol was not the primary problem. Attempts to have agency staff document alcohol involvement in everyday problems are reported in Alfano and Glassey (1988).

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CHAPTER 6

Symposium Reflections

Conducting Community Action Research

Ann Pederson, Susan Roxburgh, and Laura Wood

The Symposium on Experiences with Community Action Projects for the Prevention of Alcohol and Other Drug Problems reflected a need to learn more about the *process* as opposed to the *outcomes* of community-oriented research projects. This essay suggests ways of thinking about and conducting community action research based on the papers in this volume and records of informal discussions in plenary sessions and workshops during the symposium.

Given the orientation of the symposium toward community action research projects that had an evaluation component, the perspective taken in this essay is that of the researcher. Of necessity, this orientation minimizes the analysis of the roles of other players such as community workers or program planners in community action research. It is the task of another forum to elaborate those perspectives more fully than was possible here.

The essay is loosely structured to follow the sequence of a community research project, from planning through implementation to aftermath. We start with a discussion of underlying models and strategies for community action research and proceed to consider the task of community mobilization. Various ways of defining community and the importance of relationships among the many stakeholders in a project are subsequently outlined. The different perspectives brought to a project by researchers, program planners, and community members are briefly discussed as well as the relative merits of top-down versus bottom-up approaches to community research. Finally, we examine the impact of community action research on the community and the unique problems in conducting community action research within developing countries.

Models and Strategies Underlying Community Action Research

In the literature, the assumptions upon which many community action projects are based are seldom identified, making it difficult to compare the relative usefulness and appropriateness of interventions. Clearly explicated models of the nature of communities, human behavior, strategies for intervention, and approaches to research would assist researchers and programmers in determining what works best for the prevention of problems with alcohol and other drugs.

Blane (1976), for instance, has outlined four models used in preventing alcohol problems: the social science model; the public health model; the distribution of consumption model; and the proscriptive model. Each model incorporates a somewhat different view of alcohol problems and suggests differing courses of action. Interventions built on the assumptions of these different models will obviously vary—understanding their foundation would assist in evaluating their usefulness in a given instance.

Researchers need to examine and articulate what they mean by community action research and their reasons for adopting this approach to research. For example, is there an important difference between community-based and community action research, and if so, how would one distinguish it in practice and not just in theory? In addition, researchers need to be conscious of the assumptions they hold about the role of the community in a research projects (who controls the project design, implementation, and dissemination of findings) and the ethics of community research. Attending to some of these questions in the design phase of a project (and in its subsequent reporting) would assist others in understanding the overall context of a particular project, not just its impact.

Range of Interventions

Diverse interventions have been used in alcohol and other drug abuse prevention, ranging from educational and persuasive programs aimed at changing individual behavior to actions aimed at altering the environment of alcohol or drug use, such as regulations restricting the availability of alcohol. While increasing evidence supports the value of an environmental approach to preventing alcohol problems (Moskowitz 1989), we still need better evaluations of the efficacy of all these intervention methods. We need evaluations of these techniques when they are used individually and also of combinations of these approaches, especially if it is feasible to make an assessment of the individual rather than the combined effects.

Symposium participants noted that there appears to be an assumption that certain intervention methods are suited to particular target groups. Although it may be the case that some methods are particularly well-suited for certain subsections of the population (e.g., school children), we need to be creative and broadminded in designing interventions. It is also important to explore different ways to organize and link various intervention methods into an overall coherent strategy.

Strategies

It is useful to differentiate between strategies and methods of intervention. Methods of intervention are the specific programs, such as counseling programs, regulatory changes, or media campaigns, while strategies encompass such factors as timing, setting the stage, building coalitions, situating the intervention method within an overall context, planning the details of the intervention, and considering possible sources of long-term funding for the program should the trial prove successful. Strategies comprise overall plan of which the intervention project is a part. Whereas strategies encompass broad questions about one's overall approach to prevention, interventions are the tools by which strategies are implemented.

One approach to thinking about disease prevention and health promotion is offered by the Ottawa Charter for Health Promotion (1986), which defines health promotion as "the process of enabling people to increase control over and to improve their health." This definition has been linked to five strategies to promote health: building healthy public policies; creating supportive environments; strengthening community action; developing personal skills; and reorienting health services toward health promotion and disease prevention (Ottawa Charter 1986). Community action may encompass any or all of these approaches. For example, healthy public policies are those that serve to "make the healthy choices the easy choices" (Hancock 1982; Milio 1984) by establishing environmental conditions supportive of positive health behaviors. Local action to control and reduce alcohol consumption can be seen as an instance of healthy public policy. Overall, this approach to health promotion reminds us to design strategies and interventions that recognize that individuals act within a social-physical-political-economic environment that may support or impede efforts to improve health.

Finally, to be effective, projects may need to operate with a certain amount of "planned opportunism," that is, investigators and programmers need to be prepared to seize an opportunity to advance the project when one arises. While it is perhaps ironic to suggest that we plan for spontaneity, recognizing ahead of time that the community setting of the project will likely generate changes in the original project plan should reduce the anxieties of researchers and planners.

Community Action Research

Community action research builds on thinking and experience in the field of community development. Rothman (1970) distinguishes three types of activity under the rubric of community organization: locality development, social planning, and social action. Locality development aims to "create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance on the community's initiative" (Rothman 1970, p. 21); it is the activity that is typically referred to as community development. In contrast, social planning is a technical process of problem-solving based on rational, deliberate, and controlled change. Community participation in this method may range from extensive to minor because the main actors in social planning are expert planners. Social action, however:

> ...presupposes a disadvantaged segment of the population that needs to be organized, perhaps in alliance with others, in order to make adequate demands on the larger community for increased resources or treatment more in accordance with social justice or democracy....Social action...seeks redistribution of power, resources, or decision-making in the community and/or changing basic policies of formal organizations (Rothman 1970, p. 22).

This typology exaggerates somewhat the differences between the three forms of community organization; in practice, these orientations are often combined. Nevertheless, different professional roles and change strategies are associated with each method.

In locality development, Rothman (1970) suggests that the role of professionals is that of enabling others; hence, the process emphasizes discussion and communication. Social planning involves more fact-finding and analysis than locality development, so the role of a professional helper becomes that of technical advisor. In social action, the basic change strategies are direct action and confrontation, with the role of professional change agents shifting to that of advocacy.

Originating with the work of Lewin (1946), action research today is an amalgam of activities characterized by an explicit attempt to involve the perspectives of those people traditionally labelled the "subjects" of research into the organization, design, and implementation of a research project. This participatory nature of action research changes the traditional role of the researcher and imposes greater demands than are usual on the researcher to be disclosing and accountable; the researcher may thus become more of an advisor or facilitator than the supervisor of a project. While not all of the projects described in this volume fall under the rubric of action research as defined here, they nevertheless all involved attempts to combine action with research and thus faced dilemmas and challenges similar to those associated with the action research tradition.[1]

Community support and involvement become critical elements in the community action approach to research, which raises the question of how to mobilize support and interest within communities for research oriented toward the prevention of drug and alcohol problems.

Community Mobilization

Three issues related to community mobilization in the initial planning and assessment phase of a project were identified and discussed by symposium participants: defining a community and the implications of a given definition for a research project; the identification of key stakeholders within a community; and the respective advantages and disadvantages of "top-down" versus "bottom-up" approaches to community research.

Defining a Community

A recurrent question throughout the symposium was how to define and conceptualize community, both theoretically and practically. Defining community seems to center on two questions: Who is defining the community, and by what criteria? The first question distinguishes between objective and subjective definitions of community, whereas the second directs attention to the variety of markers that identify a community.

Conventionally, community has been defined geographically, as in "any durable local population, most of whose members belong to households based in the locality" (Tilly 1973, p. 213). Researchers often choose this view of community in planning a study because it is convenient and captures certain living arrangements which are fundamental to the research question. For example, in a study of community response to alcohol problems, the investigators decided to define the study at the level of the county because it

> ...offered the best approximation for dealing with the interplay of population patterns and institutional responses as a closed system, since the county is the government level at which most health and social service provision is organized (Room and Weisner 1988, p. 3).

It has been recognized, however, that geographic definitions of community ignore the question of the experience of solidarity among community members (Tilly 1973). We need to consider additional and/or alternative criteria for defining community.

Hillery (1983), for example, argues that three elements are necessary to define a community: a common locale; a perception of solidarity and shared activities on the part of members; and a degree of social interaction between members. The latter two elements widen the scope of our understanding of community and illustrate how settings like workplaces can be a form of community. Labonte (1989, p. 87) makes a similar distinction when he argues that community extends beyond geography and an experience of affinity to a notion of sharing:

> There is no "poor community" save poor persons coming together to share their experience and act to transform it. There is no "women's community" save two or more women sharing their reality....

These two views of community suggest a variety of possible criteria for defining a community including geography, behavior, demographic characteristics, political orientation, ethnic composition, and sense of solidarity. Sometimes, a community will be defined primarily in terms of Hillery's latter two elements, as reflected in such phrases as "the community of scholars," where no common locale (apart from institutions supporting research) can readily be identified.

Another of the strengths of these conceptualizations is their recognition of the subjective in making a determination of community. Ideally, in community action research, the community needs to be defined in terms that are recognizable to and agreed upon by members of the community. Building on an understanding of how the members of the community delimit their world, it should be possible to design a program that meets a particular community's unique circumstances and needs.

McLeroy et al. (1988) propose another conceptualization of community that may prove useful. These authors distinguish three distinct meanings of community: community as mediating structures; community as relationships among organizations; and community as power. Mediating structures are those entities that operate between individuals and the larger society, including the family, the church, voluntary associations, and other institutions (Berger and Neuhaus 1977). Mediating structures may be useful in community action as a means to support or reach individuals who are in need of services or information. In contrast, thinking of the community as a pattern of relationships among organizations focuses attention on the competition for resources that typically exists in a community, particularly in small, rural towns. Prevention workers need to think in terms of coordinating and collaborating structures in order to work within such a context for the benefit of all parties. Finally, power structures are another means of defining community:

> Power structures in cities, counties, and states, often play a critical role in defining community health problems and allocating resources — including funding, technical assistance, staffing, materials, and official and unofficial approvals — for their amelioration (McLeroy et al. 1988, p. 364).

A focus on power structures directs attention to the way in which certain issues become part of the public agenda. Alcohol and other drug use prevention workers need to recognize the interests that will be affected by their efforts.

In practice, researchers would benefit from investigations into the self-perceived definition of a community in the planning and design stages of a research project. Geographic communities may not be homogeneous entities; they are more likely to be composed of various subgroupings which when aggregated share some but not all the same views of their community. Ideally, one should involve representatives of the community of interest when assessing its dimensions. To complicate matters, however, funding or service delivery organizations may impose a definition of community upon a study (e.g., county) with which the researcher will have to contend.

If one is actually able to determine the boundaries of a particular community oneself, one approach to gathering the necessary information is to identify the key stakeholders in the community of interest and solicit their views of the community, its boundaries, and its problems.

Stakeholders

Stakeholders are people perceived to have (or who perceive themselves as having) an interest in an issue. Community action research projects inevitably involve a number of stakeholders including official community representatives, the evaluator or evaluation team, project staff, volunteers, advocacy group members, local media, members of the study population, and business interests. Each of these stakeholders has a somewhat different interest in an issue, which makes one of the critical tasks for a researcher that of understanding and addressing those various interests.

As well as the highly visible community leaders such as public officials or key business people, there will also be a group of less apparent leaders within every community. These people may be parents, teachers, medical personnel, survivors of a serious traffic crash, or members of special interest groups such as Mothers Against Drunk Driving. Identifying and involving these people in one's project should facilitate community acceptance and participation.

One group of stakeholders who may be crucial allies in a community project are the media. Providing media with information early in the course of a project may prevent subsequent misunderstanding of the project.

Community advocacy groups are also likely to be important stakeholders in an action research project. Tom Greenfield[2] emphasized that it is important that researchers consider advocacy groups as allies of the research agenda and recognize that the motivation behind the formation of many single issue groups is often human tragedy, such as alcoholism or a motor vehicle fatality. Greenfield suggested that harnessing the enthusiasm of an advocacy group could increase the likelihood of long-term funding for a project after its demonstration.

There may be some stakeholders whose interest and impact have important political consequences for a project. For instance, Robin Room suggested that external (to the community) sources of funding may undermine the sustainability of community projects by weakening community support and commitment. Political conflict over control of projects and priorities can also interfere with the maintenance of project monies, as when one level of government funds a project that is subsequently overturned by another level of government. In reality, of course, a project may have no option but to accept external funding if it is to have chance to operate.

Conflicts are likely to arise among the multiple stakeholders in a project; hence, researchers need to be prepared to spend a great deal of energy managing conflict. For instance, researchers and service agencies are likely to have differences in priorities, time frames, and values. Similarly, citizens and agency personnel may have different interests and understandings of the goals of the research or evaluation than the researcher. While researchers are likely to be interested in "contributing to the field," the non-scientific community is more likely to be looking for means to resolve practical problems (Kelly et al. 1988, p. 128).

Morell (1979, pp. 23–24) notes various sources of friction between researchers and service agencies when it comes to research: a perception that social science theory is not useful for solving social problems; the disruption of everyday working life within an agency that typically occurs during evaluation; disagreement over who controls the research process; fear of the evaluation findings ("evaluation apprehension"); and the existence of a "culture gap" between researchers and program personnel that arises from differences in training and perceived priorities.

Differences in training and expertise between the researcher and community members may also contribute to conflicts around questions of power and prestige. Kelly (1988, p. 130) warns that "professional research staff needs to be aware of the 'expert power' they inherently possess as a result of their academic background and credentials over the citizen participants." This power imbalance can be redressed to some extent by the conscious decision of the researcher to define his or her role as that of facilitator or consultant.

Defining the Problem

Ideally, a researcher would begin a project by identifying the key stakeholders in a community and would then bring them together to discuss the project and their perceptions or concerns about it.

> The first step in identifying a problem is to convene a public meeting or series of meetings with the appropriate broad diversity of interests. This group will identify an initial formulation of the problem....One useful guideline is to define the problem as "what hurts" in the community (Wallack and Wallerstein 1986–87, p. 330).

In some instances, this process will lead to a refinement of the problems the community is experiencing; in other instances, this process may lead to a complete redefinition of the focus of the project.

There may be significant differences between how researchers and the members of a community define the problem. For example, a researcher may define a community as having an alcohol consumption problem based on aggregate consumption figures in comparison to other communities of similar size, density of population, etc. The community, in contrast, may define its problem not in terms of volume of alcohol consumed, but in terms of traffic congestion (parking on streets with licensed premises), public nuisance (intoxicated citizens lying on the streets), litter, or drinking and driving. The community may want a program or service that meets their definition of the problem and not one aimed at reducing overall consumption.

In seeking to define the problem, it may be particularly difficult to work with certain entrenched interests that may benefit from the status quo. For example, alcohol prevention projects that attempt to alter overall consumption levels will likely generate controversy among alcohol producers, who will not take kindly to initiatives that threaten sales. In another example, tobacco producers and manufacturers continue to battle population-based efforts to reduce tobacco consumption.

Similarly, definitions of problems have political consequences and may thus be resisted because of the changes that must be made at a policy level. Davinder Mohan suggested that attempting policy change through community prevention projects is difficult because it threatens the status quo or challenges support for the government.

Community Assessment

The processes of defining a community, identifying its key stakeholders, and working with them to arrive at a definition of the problem can be thought of as community assessment. Having established the importance of these activities, conference participants focused on how this information could be gathered.

Wallack (1984) notes the importance of understanding the social, political, and cultural dimensions of a particular community, suggesting that an understanding of the interrelations between these factors provides the best way of designing successful intervention models. Specifically, Wallack (1984) recommends the use of systems approach to the study of alcohol problems that might include the following steps:

1. Look at the problem in its natural setting.
2. Assess the relationship between the alcohol problem and other problems.
3. Identify the stakeholders and the group who loses the most because of alcohol problems.
4. Expand the analysis to other social, economic, and political systems.

5. Identify the values that support and reinforce the present system that is sustaining the problem.

Robin Room suggested that researchers might look to other fields for models for community prevention and intervention research. An extensive review of the literature might include material from economics, marketing, sociology, psychology, anthropology, political science, and epidemiology. Unifying and underlying this type of literature exploration would be the search for material that illuminates the nature of community from the point of view of community participants.

A description of values and a community's definition of its problem are not readily available in a conventional literature review; assessing these facets of a community, therefore, requires other strategies such as key informant interviews, participant observation, small-scale surveys, and attending community forums.

Social network analysis was suggested as one tool for developing a more thorough understanding of community. In network analysis, a network is defined as a pattern of linkages between nodes in which the nodes may be individuals, households, corporations, or even countries (Wellman 1983). Nodes are linked through patterns of exchange and interaction. An adolescent drug user's network, for example, could include both suppliers and fellow users of drugs; the nodes are linked by interactions around their common substance use. In the alcohol field, Skog (1986) used a social network model to examine changes in alcohol consumption between 1851–1982 in Norway. Such analyses could generate new insights into the process of alcohol and other drug distribution and ultimately suggest ways of intervening. Network analysis can thus be seen as an independent research strategy in its own right, or as one ingredient in an overall community assessment.

A key aspect of the community assessment should be the development of a plan for the best way to proceed with a project. Of particular concern should be the question of whether to incorporate the project within existing organizational and service networks or to introduce the project through channels involving high-level official action. In other words, the question is whether to approach the community from the bottom up or the top down.

Top-down versus Bottom-up Approaches

The terms "top-down" and "bottom-up" refer primarily to whether a project is developed outside the community with little consultation and then "parachuted" into the community with high-level official support, or developed through a process of extensive consultation with the community during all stages.

Top-down approaches typically involve a policy decision by government officials (Sabatier 1986). In contrast, bottom-up approaches often start with an analysis by individuals who interact at the local level in terms of a specific social problem. The approach taken to a project may have significant impact on the extent of community ownership of and commitment to a project.

A second important distinction between top-down and bottom-up approaches concerns the specificity of the objectives of the research and intervention in the preliminary phases of the project. In the top-down approach, the study population is already identified and the program known in entirety prior to the researcher's entry into the community. In the bottom-up approach, community members are involved in specifying the research project and the development of the intervention protocol.

Symposium participants discussed the possibility of stipulating the circumstances that favor the use of one of these approaches over the other. It was agreed that a decision about approach cannot be made without an understanding of the community, although it may be possible to develop criteria that guide the adoption of an approach, once an understanding of a specific setting has been developed. In practice, the process is probably iterative and dialectical; one works from an implicit definition of community, which permits one to then identify stakeholders within a particular community. From encounters with those key stakeholders, the original definition of community may be reexamined and modified. In turn, defining the community and determining who are the key stakeholders set the stage for whether the intervention is approached from a top-down or bottom-up perspective.

Sabatier (1986) proposes three conditions for a successful intervention using a top-down approach: government officials must be committed to the intervention and have an appropriate degree of knowledge about the intervention setting; interest groups and other stakeholders must be in support of the intervention; and any change in the socioeconomic or political climate must be considered for its possible impact on successful implementation.

The most serious flaw in the top-down approach is that it concentrates on the concerns of decisionmakers and neglects the concerns of other actors (Elmore 1979). In contrast, the bottom-up approach offers the possibility of incorporating the community perspective into the design of an intervention, adapting a project to unique circumstances, and maximizing the likelihood of community support for a project. It is conceivable that a bottom-up approach may be able to develop greater long-term support in a community and thus be more readily incorporated into a local service agency, although this possibility requires empirical substantiation.

Weighing the merits of top-down and bottom-up approaches, while theoretically interesting, may ignore the limits placed on researchers and programmers.

It is not always the case that the program developer or researcher has a choice about the starting point of a project. Circumstances may dictate that appropriate levels of approval and support are necessary prior to any but the most formal contact with a community. Thus, while it may be useful to consider the differences between the two approaches, in practice the level of intervention may be influenced by the funding source, the structure of the community, or the power of the key stakeholders. Given this reality, the researcher or programmer may be required to adopt a compromise between the two approaches that incorporates those aspects of each that are appropriate for a particular community. Adopting a bottom-up approach does not diminish the importance of gaining the support of major powerbrokers. Similarily, a top-down approach should not eliminate efforts to involve other actors in the project through developing advocacy coalitions or seeking an understanding of the perspectives of those actors. Thus, the best strategy may be to combine the best features of both approaches—the official sanctioning and legitimacy of the top-down approach and the likelihood of greater community commitment and involvement facilitated by a more grassroots approach.

Community Commitment and Involvement

Linking the issues discussed to this point is the question of facilitating community commitment to and participation in a research project. When feasible, researchers and community members should work together from the early stages of a project. Involvement in the decisions that will shape the program is likely to enhance commitment to the project by community members as well as to maximize the likelihood that the project is framed in a manner that is acceptable to the community.

The credibility of researchers and program staff is enhanced if they are realistic in their appraisals of and promises to the community of the anticipated contribution of a project to alleviating community problems. Wallack (1981) suggests that, in order to gain community support, there has been a tendency in alcohol and other drug abuse studies to promise communities more than a short-term intervention project can possibly deliver. Promising the moon may gain community enthusiasm at the expense of the researcher's credibility.

Therefore, community commitment is not easily acquired and is readily shattered. Facilitating community commitment and involvement in a research project may ultimately depend on the sensitivity of the investigator and/or programmer and the extent to which issues such as the definition of the community, the definition of the problem, and the approach to the intervention are determined through consultation with the community.

Empowerment

Currently, the topics of empowerment and community organization are receiving much attention in the health promotion and disease prevention literature (e.g., Wallerstein and Bernstein 1988; Labonte 1989). In an article on planning community prevention initiatives, Wallack and Wallerstein (1986–87, pp. 323–324) offer a rationale for engaging in community organization for prevention:

> Community organizing strategies focus on the benefits of people participating in their own health....
>
> The health rationale for community organization comes from the social support literature in epidemiology, the social-psychological studies on having control over one's life, and the health and socio-economic gains from community organizing....
>
> ...community organization encompasses the view that health is a process within a system, rather than a state to be captured. A health-building process means involving people in decision-making and taking action in the context of their community priorities. A community process keeps the locus of control and consequences of actions in the community, and develops skills for ongoing program development if outside funding or personnel are withdrawn.

However, one author cautions that although empowerment is an intuitively appealing concept, it suffers from severe conceptual ambiguity:

> An idea rooted in the "social action" ideology of the 1960s, and the "self-help" perspectives of the 1970s, empowerment appears with increasing frequency in discussions of strategies for prevention and community intervention....There is an enticing promise in this orientation; we seem to resonate intuitively to its psychosocial, political and ethical connotations. But we have yet to define this term with sufficient clarity to establish its utility either for theory or practice. It is often used as if it were synonymous with concepts as varied as "coping skills," "mutual support," "natural support systems," "community organization," "neighborhood participation," "personal efficacy," "competence," "self-sufficiency," and "self-esteem" (Kieffer 1984, p. 10).

Kieffer suggests that the most useful and meaningful definition of empowerment is one that embraces all of these ideas. In other words, empowerment can mean some or all of these concepts, and it is critical to be explicit in a given context what one means.

How can researchers and program developers support empowerment? Kieffer (1984, p. 17) suggests that empowerment arises from the experience of powerlessness, and is "a process of becoming,...an ordered and progressive development of participatory skills and political understandings." Thus, empowerment is not a state but a process: "Empowerment is not a commodity to be acquired, but a transforming process constructed through action" (Kieffer, 1984, p. 27). In turn, Kieffer describes the experience of empowerment as involving the acquisition of three facets that result in what he calls "participatory competence." The first dimension is a positive self-concept. The second is the construction of a more critical or analytical understanding of the social and political environment. The third is the cultivation of individual and collective resources for social and political action (skills, confidence, knowledge, experience). This being the case, researchers and program staff should encourage and support community participation as a key aspect of a project in order to make the process as empowering as possible to community members.

Kieffer also found that a critical ingredient in the process of empowerment for many individuals is a precipitating personal event that led to the individuals decision to become involved. This notion harkens back to our earlier comment on the motivation behind the formation of many citizen's advocacy groups: In many instances, the experience of personal trauma or tragedy stimulates commitment to a cause and the formation of an advocacy group. It is unclear how researchers can use this information in project development, but it is certainly valuable to understand the motivation of participants in an advocacy group. Furthermore, Kieffer's work suggests that participation is not fostered by the same aspects of alcohol and other drug problems that interest researchers or public health professionals.

Fundamental to the notion of empowerment is the distinction between doing something "to" a community as opposed to "with" one. Again, this raises the theme, pervasive in the symposium, of collaborating with the community in designing interventions or research initiatives that meet the community's needs. However, one needs to be cautious about the role one is able to play in empowering others.

Bearing these reflections in mind, it appears that the role of the community action researcher in an empowerment process is of facilitator or enabler. The professional role is limited because one cannot empower another person, only serve to provide opportunities, support, and skills training to facilitate the empowerment experience. Even providing resources may enable effective action on the part of the community. Efforts to employ the techniques of Paulo Friere to empowerment education for alcohol and other drug abuse indicate that it may prove to be a useful method for prevention (e.g., see Wallerstein and Bernstein 1988).

It was suggested that there may be a fundamental contradiction between agencies such as research bodies supporting community empowerment when the state, operating through other agencies, perpetuates a system that minimizes public participation and sometimes supports actions that are contrary to the public's interests. This comment reminds us of the powerful interests that may be threatened by preventive efforts which extend beyond awareness-raising to political action.

Grassroots organizations can serve as important centers for learning skills and the confidence to use those skills integral to the empowerment process. Accordingly, if community action research is to assume a role in empowering individuals and groups, researchers would be wise to link their initiatives to local groups.

The Aftermath of Community Action Research Projects

When is a community research project over? Discussion during the symposium suggests that the completion of a community research project is surprisingly ambiguous in some instances and really constitutes a new phase of action. Given the multiple stakeholders in a project, there is no single aftermath of a community action research project, but rather multiple aftermaths.

Symposium discussion demonstrated that few researchers or program planners deliberately prepare and plan for this stage of a project. Concerns raised by symposium participants as important during this phase of a project included the project's long-term impact on the community, what to do with the results of a study, and the general problem of closure in community projects.

Impact of Projects on the Community

Symposium participants wondered about many aspects of the impact of projects on the community. Is there an inevitable limit to the attention that can be paid to a particular issue, or is the reduction of visible support for a program once the project is complete a function of leadership, resources, or other factors? How can researchers ensure that projects are picked up by community sponsors so that communities are not just abandoned following the completion of the research phase of a project?

In some cases, when a project involves provision of a previously unavailable service, withdrawal of resources means withdrawal of the service. Is it the reseacher's job to see that the service continues after the demonstration phase of a project? How can a researcher maximize the likelihood that a project will receive new resources when the demonstration is over? It is conceivable that community representatives might be of assistance in such instances; if there has been support and commitment from the community during all the phases of the project, there may be energy and commitment to ensure that the service is provided after the project is finished. It was suggested that projects that use local staff and/or work through local agencies will more likely be able to integrate new services into existing arrangements, though of course there is no guarantee that this will occur in a given instance.

It was also suggested that the duration of a project may have consequences for the long-term impact of a project and the likelihood of its becoming integrated into the community. Health promotion and prevention projects generally face the difficulty of trying to demonstrate impacts and outcomes for evaluation purposes when long-term outcomes may be unavailable for many years. The time frame for many projects may be too brief to demonstrate statistically or practically significant results.

Unanticipated Developments

Much of the impact of a project may be unanticipated by the research and program staff. It is difficult to foresee what events or situations will occur in the aftermath of a project or their impact on the service or program or particpants of a community research endeavor. In some instances, maintaining a project at the local level may be impeded by the original source of funding and attendant political constraints. Federal research money, for instance, is not typically given for promoting changes in local legislation.

It was suggested that sometimes a project may foster developments with which the researcher does not agree. We must determine the limits to legitimate claim of the researcher, if any, to directing the programmatic and policy choices made by former project participants. One impact of a project on a community may be that it encourages a grassroots advocacy group to reevaluate its position on a policy or to redirect its energies. More seriously, a project may have negative outcomes, such as when it produces the opposite effect to what was originally expected. Such a situation is more than a case of negative findings because there may be very significant public health consequences. A most dramatic example of such an outcome is the finding that drug education programs in some instances have led to increased drug use (e.g., Pickens 1985). Interventions may also present unanticipated positive outcomes, such as a server intervention program that fosters status and prestige among bartenders who have received the training, thereby increasing the likelihood that others will desire the training.

Sally Casswell suggested that one way to deal with unanticipated outcomes is to plan to minimize them. She also suggested that it should be an overall policy of prevention projects that they be health promoting; she cited as an example the sense in which designated driver programs implicitly sanction heavy alcohol consumption, albeit not by drivers. Such programs violate a principle of promoting health when they sanction unhealthy behavior. Thus, researchers, community representatives, and program planners need to design interventions that are unlikely to inadvertently support unhealthy behaviors.

Results

Aside from the logistical and technical challenges of evaluating community action research projects, another key point of discussion among symposium participants was the question of providing feedback to key stakeholders.

Michael Goodstadt acknowledged that the demands and traditions of academic and/or research employment are such that one is not rewarded for translating findings into information that is understandable or useful by non-researchers. The different needs for information of researchers, progam personnel, and community representatives demand that results be presented in a form that is meaningful to each group. Failing to translate results from the technical jargon of research into everyday language may reinforce barriers and power differences between researchers and the community.

Possible mechanisms to provide feedback to the community include community forums, newsletters, news articles in a local paper, the project report, presentations to the advisory group, etc. It was generally agreed that it is important that nontraditional avenues for communicating research results need to be used more frequently. Regina Caverson suggested that mechanisms be built into the "front end" of a research project to organize the dissemination of research results.

Another issue confronting community-based researchers is ownership of the results of research. Does a researcher have any rights or obligations with respect to the use of the results of a study? What is the researcher's role if grassroots or advocacy groups want to use research results to support a particular political agenda? Is the researcher to be an advocate on behalf of the program or target group of the intervention? What does an investigator do if access to the population was conditional upon the researcher being willing to speak on behalf of that population upon completion of the study?

Michael Goodstadt argued that researchers, armed with negative as well as positive findings, have a role to play in policy and program development. The various informal pressures against or impediments to the publication of negative findings may mean that important experiences with community action research are not shared.

In an empowering framework, with the researcher operating as a facilitator rather than a master of change, the researcher's is but one viewpoint to be considered in decisions about future directions for research project participants. By definition, the community or its representatives are the people to determine "what next" in any project. However, practical considerations (e.g., financial resources, personnel, time, the political climate) may impose limitations upon the possible future actions following a project.

Whether a project leads to the provision of a permanent new service need not be the only criterion for its success, although in many cases this would be a desirable outcome. Empowering community members and/or changing the knowledge and attitudes of project participants are important accomplishments in their own right. Nevertheless, the consensus was that it is important to try to secure funding in order to have programs and services continue if the community desires them, although this is probably more easily recommended than accomplished. Furthermore, ensuring that projects survive the end of the research phase of an investigation is probably easier in some settings than others. Developing nations, for instance, are unlikely to have the resources to maintain experimental projects on an ongoing basis after the research monies are withdrawn. Given the competition for scarce resources, all stakeholders in a project need to be realistic about the possibility of securing permanent funding for demonstration projects, both in the developing and the developed world.

Special Problems Confronting Research in Developing Countries

Delegates to the symposium came from 11 countries, including some developing nations. While the general discussion of community action research outlined here is applicable worldwide, in developing countries, the difficulties of such research are compounded by an overall lack of resources such as expert personnel, funding, and basic supplies. In addition, the challenges of day-to-day survival in many countries mean that the issues surrounding the use of alcohol and other drugs differ from those that concern health researchers in the developed world.

Davinder Mohan offered several insights into the particular challenge of conducting community action research in India. He emphasized that the rationale behind community research is likely to differ between developing and developed countries, with the former being concerned with the provision of essential, primary health care and the latter being concerned with excessive demands on an existing health services infrastructure arising from cardiovascular disease and the use of alcohol and other drugs.

The empowering aspect of community action research may also be a luxury of researchers in developed countries, in part because of historically different political traditions but also because of differences in standards of living that in developed nations permit attention to be directed toward issues beyond basic survival. Given differences in political and cultural traditions, strategies to reduce the use of alcohol and other drugs that are deemed appropriate will also vary between countries. Overall, such differences exacerbate the difficulty of generalizing from one experience with community action research to another, a theme that was repeatedly raised during the symposium.

Conclusion

The symposium was an opportunity for personal testimonials on experiences with community action research. It was generally agreed that this form of research is challenging because of the numerous contingencies that must be addressed in program planning, implementation, and completion. Conducting community action research is inherently a dynamic, situationally determined enterprise encompassing many players.

Researchers working within the community action approach do not yet have many landmarks to guide them, although this symposium was testimony to the breadth and depth of experience being developed in the field. Through continued sharing of both the triumphs and frustrations of various research experiences, we may gain greater insight in how to combine research and action within communities. We do know, however, that community action research is an inherently political enterprise that is likely to be most successful in those instances in which all the players are able to identify common philosophical positions, definitions of the problem, and ways to proceed. Ongoing dialogue among all stakeholders appears to be the essential mechanism for ensuring a successful community action research project.

Marja Holmila remarked during one discussion that it is very difficult to be a researcher involved in an action research program, but that the task is made easier by a team approach to projects. Holmila emphasized the value of shared responsibility for an action research project, stressing that it is difficult to evaluate a project to which one has a high level of personal commitment, as was her experience with the lifestyle education project in Finland. Perhaps a key lesson to take from Holmila's remark and the symposium as whole is that researchers working in the community cannot work effectively alone but must establish links with others who support community-based research.

Notes

1. For a fuller discussion of the principles of action research, see the case study by Martin Shain in this volume.

2. Persons cited in this essay whose names appear in the text in full without any date were symposium participants. A symposium contact list is available in appendix C.

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Lessons from Community Action Research: Experiences and Suggestions for Future Prevention Projects

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The papers in this volume examine the dynamics, tensions, and problems of community-oriented prevention research. These often personal reflections were sought in order to encourage further work in this area.

A crucial lesson gleaned from these reflections is that there are numerous players in community action research; ideally, this volume would reflect the experiences and perspectives of all three sets of key actors: investigators, program staff, and community members. These papers constitute, therefore, but the beginnings of the necessary dialogue on community action research.

The goals of community action research include social change as well as bettering our understanding of community dynamics around alcohol and other drug issues. The experiential nature of projects needs to be examined, not simply to better interpret outcomes, but to develop transferable knowledge. As noted in Room's opening paper, it may be that research and community action are not naturally compatible activities. Community groups may not be interested in prevention projects with a research focus. However, we hope that through adequate preparation, ongoing negotiations, and the careful choice of collaborators and settings, we will become more skilled at developing projects in which there is greater appreciation of the value of combining research with community action.

It is not possible on the basis of this one symposium to offer a prescription for how to conduct community-oriented research projects; hence, we offer suggestions rather than recommendations for future action.

Working Collaboratively

An essential feature of community-oriented research is that it is a collective endeavor. Researchers working in this tradition must be willing and able to work collaboratively, although the exact nature of such collaboration will vary widely across projects.

The rationale and focus of a project may be out of step with local priorities. For instance, community leaders may view certain manifestations of alcohol consumption such as drinking and driving or public inebriation as the key problem and wish to ignore issues related to alcohol availability and drinking environments that project staff wish to draw to their attention.

Dialogue and Collaborative Planning

Debate and dialogue among key interest groups increase awareness about varying perspectives, goals, models of change, working hypotheses, and interventions for the prevention of alcohol and other drug problems. Project personnel and other community members should be encouraged to discuss their perspectives in order to establish a common ground for developing and refining a project, interpreting one another's orientations as the project evolves, and assessing action steps based on the model from which the intervention was developed.

To the extent that is feasible, local personnel should be involved in the project as early and as completely as possible. Purchasing project-related goods and services locally, and recruiting community residents as project staff, may enhance the community's sense of involvement and commitment to a project.

Ongoing planning and dialogue are critical in refining a project once it is underway. The community must be involved in this process so that community members can convey their perspectives, knowledge, concerns, and insights to other project members. Researchers will need to balance evaluation and research priorities with community interests. Projects may thus involve a struggle to reach a middle ground somewhere between arbitrary directives or control from "outside" and inappropriate use of the project talent and other resources for the personal advance of local people.

Political Environment of the Project

The political climate is likely to be as important to the process and outcomes of a project as the selection of the intervention. Vested interests may be critical of specific prevention strategies that threaten local business interests.

In addition, special attention must be directed at concurrent activities in the community and how these might contribute to the success of a project. Many communities will have parallel high-profile agendas—other health issues, economic and industrial development, social services, tourism, improving goods and services—which will compete with the prevention project for attention, contributions, and official and volunteer expertise and time. It is important to convince community leaders of the value of taking an active interest in alcohol and drug issues. Ideally, a prevention campaign should be linked with activities to which there is already a strong community commitment and for which an organizational framework exists. It may be necessary to reorient the prevention activities in order to accommodate these local concerns even if these concerns are not considered central to interventions to curtail alcohol or other drug problems.

One should be prepared for struggles that may involve differences in perspectives between local experts and project personnel or competition for scarce local resources. Rifts and alliances may emerge around who has primary responsibility for certain alcohol or drug-related problems or clientele. Conflict also may arise from efforts to shift responsibility or blame up or down the jurisdictional ladder (e.g., national, regional, state, provincial, or local governments).

Ethics, Democracy, and Power

The issues of democracy and locus of control are central to debates over the relative merits of grassroots versus centralized approaches, or top-down versus bottom-up approaches. On balance, it appears that both have something to offer: for example, experts from outside the project locale or context might offer knowledge, techniques, perspectives, and other resources to complement the political power, cultural sensitivity, and skills available locally. Projects that are "parachuted in" tend to encounter problems in being accepted and finding a common ground with local officials; alternatively, projects that are dominated by an inward orientation may disregard lessons and benefits from experiences elsewhere.

Funding and Resources

Financial resources clearly have a critical role in shaping a project. This impact arises not only from the actual institutional source of funds and the perceptions of control or independence that tend to be associated with various sources, but also from the extent of funding relative to the scope and task of the project. Project managers are encouraged to seek a solid commitment from sponsors and to establish procedures whereby they can make the most of this support when the occasion arises.

Sharing the cost of the project, either through direct local financial contributions or through various "in kind" arrangements needs to be considered at an early stage. Such arrangements can enhance a project and further encourage local participation in the planning process and interest in the project impact.

Underfunding creates difficulties not only for project personnel (in that they have to curtail data collection, the intervention, or both), but also for the community. Project planning should include adequate resources for all phases of the endeavor, including the latter stages when the need for of expeditious report completion may be competing with local expectations to transfer knowledge and skills to community personnel.

In developing proposals and project plans, a larger portion of project resources needs to be devoted to preintervention activities, including developing the information base, facilitating local participation, and planning and refining the intervention. Granting agencies should ensure that a greater share of the investment is designated for preintervention aspects of projects. Similarly, granting agencies should ensure that there are sufficient funds for the analyses to be completed and the transition to post-project activities to be facilitated.

It would be helpful if granting agencies provided clearer justifications for supporting some projects over others. It is not only innovative projects that deserve wider support and require evaluation, but run-of-the mill activities that have not yet been evaluated and for which process and outcome assessments are lacking.

Research Design

Researchers need to articulate better the focus and rationale of projects, as well as their choice of target population, problem behavior, setting, and intervention. While the "community" may be the generic term for the setting of the projects being discussed, enormous variation exists in the actual settings for projects.

The overall goals of a project and a rationale for achieving them need to be specified. The hypotheses and models of social and behavioral change should be an explicit and central focus in planning prevention projects and need to be communicated to community representatives. Goals and objectives need to be developed in terms of the resources available, the extent of support, and the nature of the issues to be addressed.

Assessment and Interpretation

Data should be gathered that are relevant to a number of issues, including community needs assessment, mobilization of community interests and resources, project process documentation, and outcome evaluations.

Qualitative and observational, as well as quantitative, data should be gathered in the course of prevention projects. Plans for both process and outcome assessments need to be developed in detail as part of the program planning process.

Project design and funding arrangements should allow for some flexibility in data collection arrangements, so that research opportunities not anticipated during the planning phase but emerging during the course of the project can be used. Multicomponent assessments — involving generically different types of data or information — are encouraged even if they open the door for conflicting findings; the alternative risk of basing all interpretations or conclusions on one data set is probably a more serious one.

Background Information on the Community

Primarily due to time constraints, insufficient attention is often paid to assessing the local situation during project preparation. Obtaining background information on community structure, current priorities, dynamics, and experiences is, however, required prior to final planning and implementation.

Resources and time devoted to obtaining information and developing an awareness of the local culture and structure may avoid costly and confounding problems later on.

Confounding Events

Sometimes developments that occur once a project has begun lead to modifications in the design or complicate interpretations of the data. Unexpected developments—for example, a labor dispute that influences all study sites—may confound interpretations of the data.

Project staff may also encounter confounding events in the form of prevention campaigns emerging in control communities. While steps might be taken in an attempt to minimize damage to the project, community-oriented research in dynamic social settings is by its very nature subject to cultural events, secular developments, and unanticipated shifts in local preferences, interests or concerns.

Coordinating Research, Program, and Community Agendas

Flexibility is required in many aspects of the intervention, including staging, sequencing, and combining aspects to be responsive to project design issues, local interests, and regional or national developments that may influence local experiences.

Project personnel must also be willing and prepared to change the timetable or sequencing of proposed intervention steps in response to the immediate concerns of the community, such as drinking among teenagers, rowdiness, or public disturbances.

Regular information exchange among various project participants is encouraged. If change agents, community members, and researchers are to work together, they must share a common information base about the community. Whether sharing information will confound the evaluation of the intervention needs to be decided early in a project.

Interventions

Social Movements or Demonstration Studies?

The planning, management, dynamics, and potential impacts of projects are influenced by broader social developments. Local, regional, or national concerns and mobilization about alcohol or other drug issues may lead to citizen-generated movements, which in turn may fuel various prevention initiatives. Alternatively, funding agencies, service providers, policymakers, researchers, or change agents (e.g., community developers) may try to capitalize on citizen interests by initiating demonstration projects. Thus, some projects are part of autonomous community movements while others are demonstrations. In the former, evaluation may tend to take a second place and, in any case, be difficult to implement effectively since the intervention will be taking place by the time evaluation is planned or implemented. In the latter, developing sufficient community interest in the intervention may prove to be a more important issue.

Strategies and Multicomponent Interventions

Multicomponent interventions with a strong emphasis on persuasive or educational techniques were commonly used in the projects described here. There were also a number of projects with significant regulatory components.

Most recent community action projects in the alcohol and drug area appear to work on the assumption that multidimensional interventions are most promising, although a body of literature specifically supporting this approach has not yet emerged. In some instances, several interventions are combined in the hope that potentiating or synergistic effects will be observed.

If an intervention has more than one component or phase, particular attention must be devoted to making these components complementary and placing them into an overall strategy in order to increase the potential impact. Such factors as the sequencing, interrelationship, foci, and relative strength of educational, regulatory, promotional, and general community development activities need to be considered.

The Aftermath of Community Research Projects

Many issues need to be addressed toward the latter stages of a project, including reporting arrangements, community reactions to research observations and local project outcomes, steps to disengage from the project and the transfer of project-related expertise to more routine prevention services, dealing with the discontinuation of project funding, and the phasing out of study personnel.

Data analyses and report preparation may take more time than expected, although in order to increase the options for continuation of services or to provide suggestions for project transfer, reports should be available before the field work is completed. Further, energies devoted to project transfer and coordinating the development of recommendations may detract from developing the final report. Collaborative reporting arrangements have both drawbacks and advantages. For example, community expectations, particularly those of key officials, may color the report; if the role of community is minimal, inaccurate interpretations or impractical suggestions may find their way into the report.

A key objective of this phase is to “hand off” project learning and experiences in the local setting, and thereby facilitate transfer of expertise and implementation of suggestions arising from the project.

Future Initiatives

Discussions in conjunction with the March 1989 symposium indicated considerable enthusiasm for the topic of community action initiatives. Theoretical and practical information on prevention-related community development is, however, currently an underdeveloped resource. Sponsorship and support arrangements should be designed to facilitate the exchange of ideas and practices with those areas in the social and health fields that are conventionally not involved with alcohol and drugs. Furthermore, researchers and project personnel from both fields could benefit from the development of handbooks or guidelines on community action research.

Clearly a symposium involving about 60 participants over 5 days cannot comprehensively examine all key issues. It is hoped that others will pick up the threads and themes that emerged during the deliberations at the Toronto meeting and continue the development of our knowledge and skills for community-oriented prevention research.

Appendix A

Reports of Four Workshops

During the course of the symposium, four workshops were conducted to provide participants with an opportunity to share experiences and ideas and, ultimately, to develop recommendations for undertaking community prevention efforts. A sequence of topics, beginning with the question of how to define a community and ending with how to develop handbooks or guidelines for conducting projects, was discussed. Specifically, the workshop topics were as follows:

1. Developing frameworks and models for community development and impact assessment.
2. Fostering local interest and long-term expertise for prevention.
3. Exchanging information between researchers and prevention workers and refining documentation processes.
4. Developing guidelines or handbooks for community action research.

The workshop reports were developed from notes taken during the sessions.

Harold Holder

Workshop 1: Frameworks and Models for Community Development and Impact Assessment

Workshop Participants: Harold Holder, Coordinator; Ann Coulter, Stig Larsson, Sandra Putnam, Robert Reynolds, Robin Room, Bob Saltz, Chuck Simmons, Robert Simpson, Wayne Smith.

Definitions

Community may be defined in at least two ways: as a system of social, cultural, and economic interactions; or as a geographical or political entity (e.g., governmental boundaries or media marketing areas).

We recognize that communities are long-term social systems that have cultural continuity and shared functions, yet community prevention projects are often oriented toward local geography rather than interacting social networks. The geographical unit is valuable for determining population-based denominators in incidence rates. However, communities are also meaningful social units to people.

A familiar geographical definition of community is a political definition, such as a county. Recently, new possibilities for specifying community in terms of geography have emerged.

The concept of market is widely used in business and is increasingly used in some types of research, such as marketing research. Markets can be determined by such markers as postal codes or by the boundaries of broadcast areas for electronic media. Marketing areas have been used to identify the placement of fast food outlets and to determine where cable television will be offered or billboards will be placed.

For instance, a community could be defined in terms of media marketing areas. Such areas are those served or targeted by specific mass media—local television, radio or newspapers. Boundaries for media marketing areas need not necessarily coincide with more traditional political boundaries, such as the county. The media marketing area may be either larger or smaller than a defined county. Media marketing definitions of communities may become increasingly useful as people become more media dependent and less involved with neighbors and neighborhoods and as media become more salient transmitters of values and beliefs.

Development is defined as intentional intervention in the natural order, and *impact assessment* is defined as documented change in the system arising from an intervention. *Community development* (or *organization*, *action*, or *empowerment*) refers to purposeful intervention into a community system and is often used to prepare the ground for an intervention. Community development is a means, not an end.

Community development entails a high degree of nonprofessional participation. At least two styles or meanings of community development exist. One is to increase the networking, negotiation, and linkages between professionals and institutions. The second is to increase the ownership and participation of community members (including professionals as community members) in issues and problems.

The Cultural Myth of Community as a Prairie Town

A common error in the social science research literature on community is the presumption that communities are small, isolated areas, for example, a prairie town. In reality, most people do not live in such towns. In this traditional view of the small town, the cultural (symbolic) and geographical and political boundaries coincide. In contemporary society, however, there is less likelihood that those features will coincide. Multiple and overlapping communities exist within cities; large cities may, in some senses, be collections of "prairielike" towns. There may still be places, however, such as mining towns and residential colleges, where such simpler models of community can be used fruitfully.

Although it is inaccurate to define community as identical with a neighborhood, we know that neighborhoods are an important aspect of defining community for residents. A neighborhood can be influenced by activities occurring in other neighborhoods and such interrelationships may be useful in preventing alcohol and other drug problems.

We must recognize that some people cannot be reached by traditional community interventions. The presence of tourists and other transients complicates the identification of community residents and the delivery and evaluation of prevention services. Some populations of alcohol abusers (e.g., homeless people who are alcohol dependent) are thus excluded from some notions of community. We must take care to see that appropriate definitions are adopted for a given prevention program; we must ask who is included or excluded from an intervention by the adoption of a particular view of community.

Characterization of Models of Community Prevention Interventions

Often prevention projects deal with the community as if it were a "black box," the insides of which are unknown. Thus, we subject a community to an intervention and document the outcome without much understanding of how the community facilitates or impedes the outcome of the intervention. For instance, we know little about how the infrastructure of a community (e.g., network of social services) facilitates or impedes a prevention initiative. We are often left in the dark following an evaluation of an intervention because we know little about the interaction between the structure of a community and an intervention.

In addition, we often do not understand the way in which the intervention itself operates within a community system. Measuring outcomes in terms of aggregate indicators (e.g., change in overall consumption of alcohol) without considering the structure, network, or interactions that might produce the indicator, is an example of the black box model of interventions.

Conventional approaches to evaluation, with their emphasis on outcome measures, do not alleviate our lack of understanding of the nature of communities and of how interventions function. We need to know more about the mechanisms of prevention interventions, as well as any differences between short-term and long-term changes and the difference between interventions based on single methods and those based on multiple actions.

We need typologies of communities to facilitate a better match of interventions to communities. Such typologies should reflect clusters of characteristics to guide the selection of interventions. For example, in communities where the focus of interventions has been on particular drinking environments, prevention interventions have shown the clearest effects.

In addition, local prevention programs seem to be effective where there is a policy or normative change to support the desired change in behavior. Recent experience with reducing tobacco use seems to demonstrate this pattern. The scientific results used to inform public policy on tobacco came from national studies and were supported by the highest public health authorities. There has been a shift in smoking policy from the national to the local level in the past 10 to 15 years, during which victims' rights and public health concerns about tobacco came together. What can we learn from changes in smoking behavior? Can the experience with reducing tobacco use serve as a model for alcohol and other drugs? Are alcohol problems and other drug use more complex than tobacco use? From our experience with reducing tobacco use, we may be able to identify forces we can use to facilitate change in alcohol and other drug abuse and use.

Distinguishing Between Community Action and Community-Based Interventions

What do we mean by prevention action at the community level and by community-based interventions? In recent heart disease community prevention studies, many interventions are targeted at high-risk individuals within a community, but few structural changes are made in the community itself. There is no attempt to engage individuals in the process of change beyond altering their individual lifestyles. Such projects would appear to be community-based rather than community action interventions.

Prevention of alcohol and other drug problems will often involve changing structural arrangements that affect abuse and use, for example, drowning deaths with alcohol involvement or adolescent use of cocaine. However, it is more difficult to produce structural changes than to effect short-term changes in behavior.

Schools and workplaces are institutions within communities. If interventions are targeted toward institutions without addressing the larger community context of alcohol and other drug use, they may not have long-term effects. Therefore, we need to affect the structure of the community, not simply to target institutions in the community. Changes in norms, values, and economics bring about structural changes in communities.

Impact Assessment

Changing outcomes at the community level is the goal of most prevention programs, but this goal may not be that of the community itself. We need to distinguish between the community's expression of concern (possibly led or reflected by opinion leaders) and the public health concerns of professionals.

We need to ask what we mean by impact assessment. In a given instance, is it intervention specific (e.g., reducing blood alcohol levels of patrons leaving targeted bars), or are we interested in more global effects regarding whatever is done in the community (e.g., reducing motor vehicle crash injury rates)? Does research bias the nature and development of community action programs? Have we emphasized evaluation at the expense of understanding in traditional impact assessments?

Funding often requires that a program demonstrate short-term effectiveness; this requirement drives the process and forces compromises in programming and assessment. These compromises keep us doing black box research.

Recommendations

1. More theory-driven research should be initiated. For example, how can systems theory and social network theory contribute to our understanding of alcohol and other drug abuse and use and community action? In addition, we should bring theories of social change to bear in our research.
2. The definition of community used in prevention projects should be specified to address two dimensions: (1) culture, norms, and interaction, and (2) geography and politics. It is time to move beyond the implicit model of the prairie town and develop typologies of

communities from the perspective of different intervention strategies appropriate for different communities. Definitions of communities should reflect various perspectives. Community organizers see the community in terms of social networks and stable interactions. Evaluators and researchers who need to develop population-based indicators and rates are likely to use geographical and politically defined boundaries.

3. We should stress an interdisciplinary focus in community action to include fields such as political science, public health, sociology, anthropology, and psychology.
4. We should undertake long-term followup studies for communities, similar to long-term patient recovery followup. Impact evaluation should be driven not only by funding expectations for success but also by the desire to understand the situation—what did or did not work and why. Community and program processes should have at least the same priority as impact assessment. We should avoid the black box approach to intervention (in which community systems and social processes are unknown or hidden) and document community programs and processes as well as impact evaluation.
5. Research should identify and capitalize on national or State policies in planning interventions and study the effect of natural experiments on communities.
6. Different methods of data collection, including observational and qualitative data, need to be seen as legitimate and crucial for documenting community impact and understanding community processes.
7. It is important to study autonomous social movements in which no professional change agents are involved. Spontaneous changes are most important to understand, and people and resources are needed to undertake documentation and evaluation of grass-roots community movements.

Workshop 2: Fostering Local Interest and Long-Term Expertise for Prevention Agendas

Workshop participants: Sally Casswell, Coordinator; Peter Anderson, Regina Caverson, Peter Conley, Tom Greenfield, Marja Holmila, Gerjo Kok, Ernie Lang, Nadia MacDonald, Paula Pranovi, Barbara Ryan, Paula Stanghetta, Shoshana Weiss.

Community Perspective

Alcohol and other drug problems exist on community agendas independently of the activities of prevention professionals or programmers. How a community defines such problems may be different from how various professionals might define the situation. However, the task of generating interest in alcohol and other drug issues can be minimized if those community interests are taken into account. Invariably, communities experience incidents that provoke interest and concern, although often such incidents are tragic events. The challenge for researchers and programmers is to focus that interest and concern within a prevention agenda and to sustain it over the long term to support strategic planning for reducing alcohol and other drug problems.

Focus of Prevention

We must ask ourselves if the focus of prevention efforts is health promotion, which means defining problems very broadly, or if we are going to approach the prevention of alcohol and other drug problems as a specific prevention agenda. Within the context of the new public health, it is critical to include alcohol and other drug issues in health promotion initiatives such as "Healthy Cities" projects. There is, however, the risk that without advocates, these issues will be lost in the larger health promotion agenda. In addition, health promotion activities may not directly address issues related to public decorum and social norms. Thus the workshop topic was redefined as "Fostering Local Interest and Long-Term Expertise for Health Promotion and Problem Prevention Agendas."

Goals

Goals for prevention agendas must reflect the complex and dynamic nature of alcohol and other drug use. A fundamental governing principle for prevention is that all action regarding these issues should be health promoting. For example, some interventions, such as designated driving programs, may simultaneously discourage and encourage heavy alcohol consumption. It can be argued that such programs implicitly sanction heavy drinking by other members of the group and thus constitute a threat to health.

In establishing goals for prevention interventions, a definition of community must be delineated. Different definitions of community may be useful in different contexts. For example, in some instances it may useful to adopt geographic definitions of community; in others, a definition based on socioeconomic or behavioral criteria may be more appropriate. We must recognize that there may not be a common understanding of the nature of the community in a particular instance. Community analysis in the context of the specific research issue is thus important for establishing the definition of community appropriate for a given project.

Structures

An understanding of community structures, formal and informal, is essential to developing the productive partnerships in support of prevention activities. Such understanding of the community, in turn, may foster understanding of the dynamics of interaction between the various professionals (researchers, program planners, developers, and implementors) and community members.

If communities are to assume ownership of prevention activities, mechanisms to assure full participation of community members in the process must be established at the earliest planning stages. Collaboration is the key to the success of community projects, and involvement of community members in the three critical phases of developing a project is advocated:

1. A development phase to identify internal structures of the community and its institutions.
2. Community action research with community members providing their "best advice" and guidance.
3. Communication activities to disseminate information on the monitoring and evaluation aspects of the project.

Funding

Resource development and allocation are important components for assuring long-term community investment in prevention. In wealthier nations, sometimes the problem is not underfunding but inappropriate funding. For example, some projects may be extensively funded although their efficacy has not been empirically determined because they are not challenging to the status quo. In less developed countries, however, funding per se is a central concern. If there is community support for a project, it may be easier to generate institutional support. Such participation would reduce the abandonment of projects when professional support is withdrawn.

Flexibility in allocating resources would permit funders to respond more readily to community prevention initiatives. Often a lack of information on funding opportunities prevents organizations from gaining resources to support activities. Dissemination of such information should be considered a part of community-empowerment activities.

Volunteers play an important role in prevention activities in the alcohol field. Although we want to understand how to increase volunteer commitment, we must also recognize that volunteers, as well as fulltime staff, may suffer from "burnout." We must take the demands of volunteering into account when we ask for volunteers on a particular project.

Strategies

In establishing community action plans, intervention professionals must specify and negotiate objectives with community representatives. The extent and nature of community participation will have to be examined and plans to modify the level of commitment may need to be developed.

Preproject development activities must be undertaken. Community members, research personnel, and program staff must develop a collaborative relationship that facilitates community participation in designing the project, particularly the actual intervention, while maintaining professional input. In turn, such a relationship should enable the research and program staff to develop a field knowledge of the community.

To accommodate the dynamic nature of communities, longer term projects are required. Such projects should include regular, interim feedback to community members regarding the process and progress of the project, including short-term objectives. Providing such feedback is part of the technical function of the researcher, who must translate findings into language suitable for a wide range of interested parties.

Research during the planning phase and throughout the project can contribute to quality assurance and the accountability demanded by both community members and funders.

Recommendations

To foster community interest in projects to prevent alcohol and other drug abuse and use, and to foster expertise in such projects, we need to establish the following:

1. Multidimensional strategies with enough flexibility to respond to community concerns.
2. Resource structures designed to maximize community participation and ownership.

3. Heavier emphasis on the developmental phase of programs to promote effective reporting, documentation, and quality assurance.
4. Communication between the research and front-line elements of projects.
5. Research action projects within the broader health promotion context.

Workshop 3: Exchanging Information Among Researchers and Prevention Workers and Refining Documentation Procedures

Workshop Participants: Kathryn Graham, Coordinator; Jonathan Chick, Robert Denniston, Linda Jo Doctor, Joyce Gordon, Alexander Glazov, Louis Gliksman, Louis Molamu, Carol Savage, Ignacy Wald.

Stakeholders and Participants

For purposes of this workshop, researchers were defined as those conducting community action research, as well as those doing research that might be relevant to community action. Prevention workers were broadly defined as all other stakeholders in the conduct, implementation, and impact of action research. These other stakeholders include community developers, program planners, community implementers, volunteers and voluntary organizations, grass-roots action or lobby groups, the specific target population, the general public, funding agencies, politicians, and commercial and production interests.

These groups include a great diversity of views and values. Part of the communication process should be to identify shared values. For example, there are different perspectives on the meaning of prevention; that is, the perspective of generalized health promotion versus a focus on prevention of specific harmful actions. Communication requires identifying common values as well as issues on which values may conflict. For example, concerns in health promotion about risk avoidance and risk reduction blur the differentiation between primary and secondary prevention of alcohol and other drug problems. This blurring may change the impact or implementation of specific programs supported by some stakeholders.

Effective exchange of information requires a *reciprocal* flow of information among *all* stakeholders and researchers. Project documentation should provide necessary information about specific actions, process, and outcomes in a variety of formats relevant to each stakeholder. This documentation ensures continuation and replication of successful prevention interventions. In addition, the documentation process should facilitate future involvement in action research.

Documentation and Communication Problems

Within prevention projects and interventions, communication needs vary. Communication is required to fulfill the following functions:

- To assist program staff to develop feedback, assessment, and evaluation tools for ongoing use.

- To establish stages of communication within a project: initial assessment of problems, setting goals, determining target groups, developing action strategy, developing ways of monitoring the intervention, assessing the evaluation process from different perspectives.
- To document the action research process to ensure that the program was delivered and to describe the process for potential replication.
- To document outcomes and other research findings, including identification of necessary skills and division of responsibilities among prevention workers and research staff.
- To maintain the interest and enthusiasm of stakeholders by providing ongoing feedback.

For successful action research, it is essential that an ongoing dialogue be established between researchers and program developers, implementers, and funders. This dialogue can be facilitated by including all groups involved in prevention programming as participants in meetings and conferences and by making research results available in a timely manner and in a variety of formats.

In addition, the style and development of action research may need to change to facilitate communication. For example, researchers could use agents already in the system, rather than parachuting researchers in and out of target communities. Similarly, programmers could invite researchers into the process at the beginning of a new intervention rather than later, as usually happens.

Two groups that are often ignored in planning communication strategies are politicians and the general public. There is a need to influence legislators and to provide more information to the general public, especially in terms of countering lobbying by the alcoholic beverage industry and other vested interests. Funding for action research should include provisions for multilevel dissemination of findings because, at present, dissemination of findings tends to be done poorly. Researchers are reluctant to promote particular programs or assume an advocacy role because of potential conflicts of interest regarding future research projects. Moreover, many researchers lack the appropriate skills, motivation, and incentives—as well as the mandate—to step outside the research role and assume a lobbying role. One way for researchers to maintain a primarily scientific role is for project personnel to identify willing translators for research findings, such as newspapers (especially science writers) and interested, existing lobbying groups.

Recommendations

Workshop participants recommended a number of strategies to improve information exchange between the various groups involved in a research project.

Many of these recommendations appear to be common sense, but the frequency with which common-sense communication strategies have been ignored by action researchers suggests that even obvious strategies should not be ignored in the recommendations.

Workshop participants identified two dimensions for conceptualizing communication strategies. The first dimension incorporates the distinction between general information exchange and communication for purposes of disseminating and using research findings. In the past, the major communication focus for action research has been unidirectional, that is, communication was seen to consist of the one-way dissemination of research findings. However, reciprocal information exchange is essential in facilitating the design and conduct of useful action research projects.

The second dimension differentiates between communication relating to a specific project and communication relating to the general area of prevention. Again, in the past, *communication* was often narrowly interpreted to mean communication of the results of a specific research project by the principal investigator. To promote better communication among researchers and prevention workers, researchers should be willing to undertake communication actions that are relevant to their general areas of interest as well as to specific projects. The following diagram shows the four cells created by the two dimensions that provide a framework for communication strategies.

	Related to a Specific Project	Related to the General Area of Prevention
General Information Exchange		
Disseminating Research Findings		

Combining the two dimensions results in four areas that can be used to categorize specific action recommendations regarding communication. For example, in the following list, the recommendation to "identify stakeholders" is relevant to all four cells; however, the recommendation to "engage with stakeholders in all stages of the project" applies primarily to Cell 1 (general information exchange related to a specific project). On the other hand, the recommendation to "be willing to give 'best advice' based on current knowledge of research" applies primarily to Cell 4 of the diagram (disseminating research findings concerning general issues of prevention). The value of the two-by-two table is to clearly describe action research communication as a broadly defined reciprocal process among researchers and prevention workers.

The workshop participants recommended that researchers enhance communication through the following actions:

- Identify stakeholders in specific action research projects and in the general area of research.
- Engage with stakeholders in all stages of the project from assessment of the problem to identifying ways of presenting results.
- Provide early, regular, and timely feedback to stakeholders.
- Include incentives, rewards, and recognition to people participating in research projects.
- Develop empathy and respect for other stakeholders.
- Be available to community groups to discuss the project and the research findings.
- Periodically review reports of implementers.
- Listen to community experiences and needs in designing action research.
- Spell out implications of research for programming, policy, and continued funding.
- Build into the final report descriptions of how findings can be applied.
- Engage in a midcourse exchange of information about project revision.
- Document the process to ensure that the program was delivered and to describe the process for potential replication.
- Enroll in training in how to respond to media and various stakeholder groups.
- Be willing to interpret research findings for nonresearcher and make recommendations (i.e., provide "best advice").
- Actively seek out forums to promote innovative, successful interventions and to be exposed to other prevention experiences.
- Produce reports suitable for dissemination to nonresearch stakeholders, in addition to reports for scholarly publications.

Workshop 4: Developing Guidelines or Handbooks for Community Action Research

Workshop Participants: Martin Shain, Coordinator; Susan Garceau, Norman Giesbrecht, Michael Goodstadt, Richard Jenkins, Brian Wilbur, Friedner Wittman.

Need

Handbooks of community action are needed as a reference source for researchers, community developers, and community members engaged in prevention endeavors. These documents should clarify concepts, as well as provide technical and organizational assistance for community prevention. We need to develop guidelines, based on diverse experiences and consultations, for community action—or at least provide a framework for such guidelines. These guidelines, in turn, might serve as a preliminary step to developing handbooks for community action research.

Audiences

There exist several possible audiences (for guidelines and handbooks), each with different needs. The potential audience includes community members, researchers, and those who operate as facilitators between the community and the researcher (e.g., community developers, health policy professionals, and planners). Within each of these audiences there might be more specific needs, as follows:

- There may be community groups that need briefer, more succinct presentations.
- Community organizers may need more comprehensive information to prepare for coordination of multicomponent initiatives.
- Community action researchers may require detailed information of a more technical nature.

Levels

Guidelines and handbooks can exist in different forms. For example, a guideline could aim to be a definitive, large document of current knowledge and state-of-the-art prevention experiences. Alternatively, a guideline might be preliminary, assembled quickly to respond to current needs and to disseminate information as swiftly as possible.

Components of Guidelines or Handbooks

There are three main components of guidelines: a generic or core component focusing on process issues; modules describing specific issues and strategies; and additional components that provide information on resources and institutions. The first component, dealing with underlying or basic process issues that do not change substantially from one context to the next, could be relevant to a number of substantive prevention topics and would have a reasonably long "shelf life." The experiences bearing on the issues and the strategies modules would change more rapidly; therefore, these components would have to be updated regularly to reflect, for example, shifts in public interest and action or changes in beverage control laws. The core component might potentially serve different countries or regions within a country, whereas the inserted modules would need to be adapted to reflect experiences and expertise from different settings and countries.

Suggested Topics for Guidelines and Handbook

Five main topics need to be addressed in this type of document. These topics include the philosophy of or orientation to community action projects, models of community and community change, group development, strategic assessment, and tasks related to community action initiatives. These topics are discussed in more detail, as follows:

- *Orientation to community action.* The philosophy of community action research used in the handbook or guideline should be explicitly stated. The document should be explicit about the orientation, values, and perspective taken, such as the following: an etiological perspective on the problems to be addressed, the community groups involved or affected by the problem, the respective roles of individuals and groups in addressing the problems, the specific aspects of the situation or behavior that need to be changed, and the resources necessary to bring about the change.
- *Models of community and community change.* These models might include assumptions about communities and ways of effectively bringing about community change. These assumptions have a bearing on what interventions are planned and how the interventions are expected to bring about progress toward the desired goals. Whereas goals or activities, or both, are typically explicit in reports on prevention initiatives, the rationale of how the activity is expected to lead to the desired changes needs to be explicated.
- *Group development.* A key function of community action projects is that of bringing together new or existing interest groups and contributing toward group dynamics to facilitate prevention activities. Because conflict and debate are typical of community initiatives on alcohol issues, the

handbook might also address such topics as preparing for conflicting perspectives, using them to increase awareness, and resolving conflict.

- *Strategic assessment.* This topic includes needs assessment, problem identification, and priority setting. This topic complements problem identification, orientation, and models of change. Background information for strategic assessment might include directions for instrumentation, as well as procedures bearing on developing profiles of local problems, needs, and setting priorities.
- *Tasks.* A description of tasks would be the main "how to" section of the handbook and would outline various approaches or responses to a range of issues related to alcohol and other drugs. This material would likely be more tailored to substantive topics for prevention and local situations and, therefore, might be varied or regularly updated.

Additional background material might include educational aids to help the various audiences and participants in these projects clarify the philosophical premises, concepts, and processes (e.g., group dynamics) involved.

Because there is a great demand for similar guidelines in other fields, it may be possible to be generic, particularly with the philosophical background material and descriptions of process (e.g., group dynamics), so that relevance to other health issues is enhanced.

Conclusion

There is value in conducting a preliminary search for existing guidelines on community action and community action research. Community guides and handbooks take considerable time to prepare and to review and approve. Therefore, there is some benefit in including efficient arrangements for updating and revising so that nongeneric components are as current and relevant as possible.

There currently exist a few well-developed examples of this "Core-Module-Resource" approach in the organization of materials. The *Action on Alcohol* kit, consisting of nine modules, was developed by the Alcohol Research Unit, in association with the Alcoholic Liquor Advisory Council of New Zealand.[1] A second is the *Manual on Community Planning for Prevention of Problems with Alcohol Availability* by Friedner Wittman and Patricia Shane.[2] Third, a document developed in 1988 for the Ontario Ministry of Health entitled *A Framework for the Response to Alcohol and Drug Problems in Ontario* includes guidelines for a wide range of responses to drinking-related problems.[3]

Notes

1. Available from Dr. S. Casswell, Director, Alcohol Research Unit, Department of Community Health, School of Medicine, University of Auckland, Private Bag, Auckland, New Zealand.

2. Available from Dr. F.D. Wittman, Community Planning Project, Institute for the Study of Social Change, University of California, 732-C Addison Street, Berkeley, CA, 94710.

3. Available from Ms. Debi Mauro, Executive Director, District Health Council Program, Ministry of Health, Government of Ontario, 6th Floor, 15 Overlea Blvd., Toronto, Ontario, Canada M4H 1A9.

Appendix B

Symposium on Experiences With Community Action Projects for the Prevention of Alcohol and Other Drug Problems
The Guild Inn, Scarborough, Ontario, Canada
March 11–16, 1989

SATURDAY, MARCH 11, P.M.

8:00 Reception

SUNDAY, MARCH 12, A.M. Chair: Norman Giesbrecht

9:00 **Introduction and Opening Remarks**

9:30 **1. Overview**

Robin Room
Community action and alcohol problems: Some historical perspectives.

Panel: Peter Conley, Michael Goodstadt, and Ignacy Wald

11:00 **2. Issues in Action Research**

Harold Holder and Norman Giesbrecht
Concepts and issues for community-based action to prevent alcohol and other drug-related problems.

Stig Larsson
Ethical and political issues encountered in conducting community action programs: Experiences from the Kirseberg Project in Sweden.

Michael Goodstadt
The reality of the community *versus* the control of research.

Discussant: Robert Markosky

MONDAY, MARCH 13, P.M. Chair: Robert Denniston

1:30 **3. Societies as the Target Population**

Ignacy Wald, Aleksander Markiewicz, Jacek Morawski, Jacek Moskalecz, Janusz Sierosławski, Gażyna Świątkiewicz, and Antoni Zieliński
Progress report on the Polish community response study.

Louis Molamu
Alcohol research and public policy in Botswana.

Shoshana Weiss
Experiences with the Kibbutzim's project for the prevention of excessive drinking.

Discussant: Jonathan Chick

3:30 **4. Multidimensional Approaches**

Norman Giesbrecht, Paula Pranovi, and Laura Wood
Research agenda and community interests: Lessons from a prevention project.

Catherine Harrington, Sandra Putnam, William Waters, Ann Thacher-Renshaw, and Violet Morin
A community-based approach to preventing alcohol-related injury: A preliminary process assessment.

Regina Caverson
A programmer's perspective on implementing and evaluating a countermeasure at the community level.

Discussant: Barbara Ryan

TUESDAY, MARCH 14, A.M. Chair: Peter Conley

9:00 **5. Policy and Regulation**

Friedner Wittman
Community planning for prevention of alcohol problems: An environmental perspective.

Ronald Douglas
Formulating municipal alcohol policies: Community action experiences of a change agent.

Barbara Ryan and Robert Reynolds
An applied systems approach to reduction of alcohol problems in San Diego, California.

Discussant: Wayne Smith

11:00 **6. Community and Schools**

Linda Jo Doctor and Dennis McCarty
Primary prevention centers and the development of community-supported school-based alcohol and drug abuse prevention programs.

Mary Ann Pentz, Patricia Alexander, Calvin Cormack, and John Light
Community-based alcohol and drug prevention: Experiences of the Midwestern Prevention Project.

Discussant: Ken Allison

TUESDAY, MARCH 14, P.M. Chair: Harold Holder

1:30 **7. Server Interventions**

Eric Single
Server intervention experiences in Ontario.

Louis Gliksman
Evaluation of a server intervention program: Confessions from the field.

Cathie Delewski, Robert Saltz, and Jim Mosher
Evaluation of a community-based server intervention program.

Discussant: Lawrence Ross

3:30 **8. Workshops**

1. Frameworks and models for community development and impact assessment.
   Coordinator: Harold Holder
2. Fostering local interest and long-term expertise for prevention agenda.
   Coordinator: Sally Casswell
3. Researchers and prevention workers: Exchanging information and refining documentation process.
   Coordinator: Kate Graham
4. Developing guidelines or handbooks for community action research.
   Coordinator: Martin Shain

WEDNESDAY, MARCH 15, A.M. Chair: Louis Gliksman

9:00 **9. Workplace and the Community**

Martin Shain
Worksite community processess and the prevention of alcohol abuse: Theory to action.

Marja Holmila
Life-style issues—debate and action in the Finnish trade union movement: Experiences of an action research project.

Davinder Mohan, H.K. Sharma, and K.R. Sundaram
Health education intervention approach in the prevention of drug abuse: An evaluation study.

Discussant: Gerjo Kok

11:00 **10. Prevention and Treatment**

Jonathan Chick
Community planning for the prevention of alcohol problems: Integration of treatment services and community action initiatives.

Robert Simpson and Paula Stanghetta
Planning and implementation of comprehensive alcohol and drug services.

Alexander Glazov, Michael E. Kuznets, Alexey A. Poluboyarinov, and Michael G. Tsetlin.
The system of early identification and prevention of alcoholism and drug dependence in a technical school.

Discussant: Peter Anderson

THURSDAY, MARCH 16, A.M. Chair: Martin Shain

8:20 Peter Anderson
Seminar: Alcohol consumption and health—a review of the epidemiological literature.

9:00 **11. Special Populations**

Ernie Lang and Marian Kickett
Program to combat petrol sniffing in aboriginal communities in Western Australia.

Kathryn Graham, Sarah Saunders, and Margaret Flower
Approaches and agenda of researchers or evaluators versus those of community developers: Perspectives of the program developer, the program manager, and the program evaluator.

Louis Gliksman
Campus Alcohol Policies and Education Program (CAPE): Practical considerations in a research evaluation.

Discussant: Nadia McDonald

11:00 **12. Workshops [continued]**

THURSDAY, MARCH 16, P.M. Chair: Martin Shain

1:30 **13. Continuity in Research and Community Action**

Sally Casswell
Aftermath of the Community Action Project on alcohol: Integration or attrition?

Panel: Marja Holmila, Davinder Mohan, and Robert Reynolds

6:00 **14. Workshops [continued]**

8:00 SYMPOSIUM BANQUET

FRIDAY, MARCH 17, A.M. Chair: Robin Room

9:00 **15. Workshop Reports**

10:00 **16. Summary Session: Themes, Interpretations, and Recommendations**

11:00 **17. Summary Session [continued]**

12:00 **18. Closing Session: Postsymposium Plans**

Rapporteurs

Introduction and Overview:	Tom Greenfield
Issues in Action Research:	Carol Savage
Societies as the Target:	Joyce Gordon
Multi-Dimensional Approaches:	Chuck Simmons
Policy and Regulation:	Jonathan Chick
Community and Schools:	Donna Heughan
Server Interventions:	Brian Wilbur
Workplace and the Community:	Ernie Lang
Prevention and Treatment:	Ronald Douglas
Special Populations:	Friedner Wittman
Continuities in Research:	Joyce Gordon
Summary and Closing Sessions:	Laura Wood

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